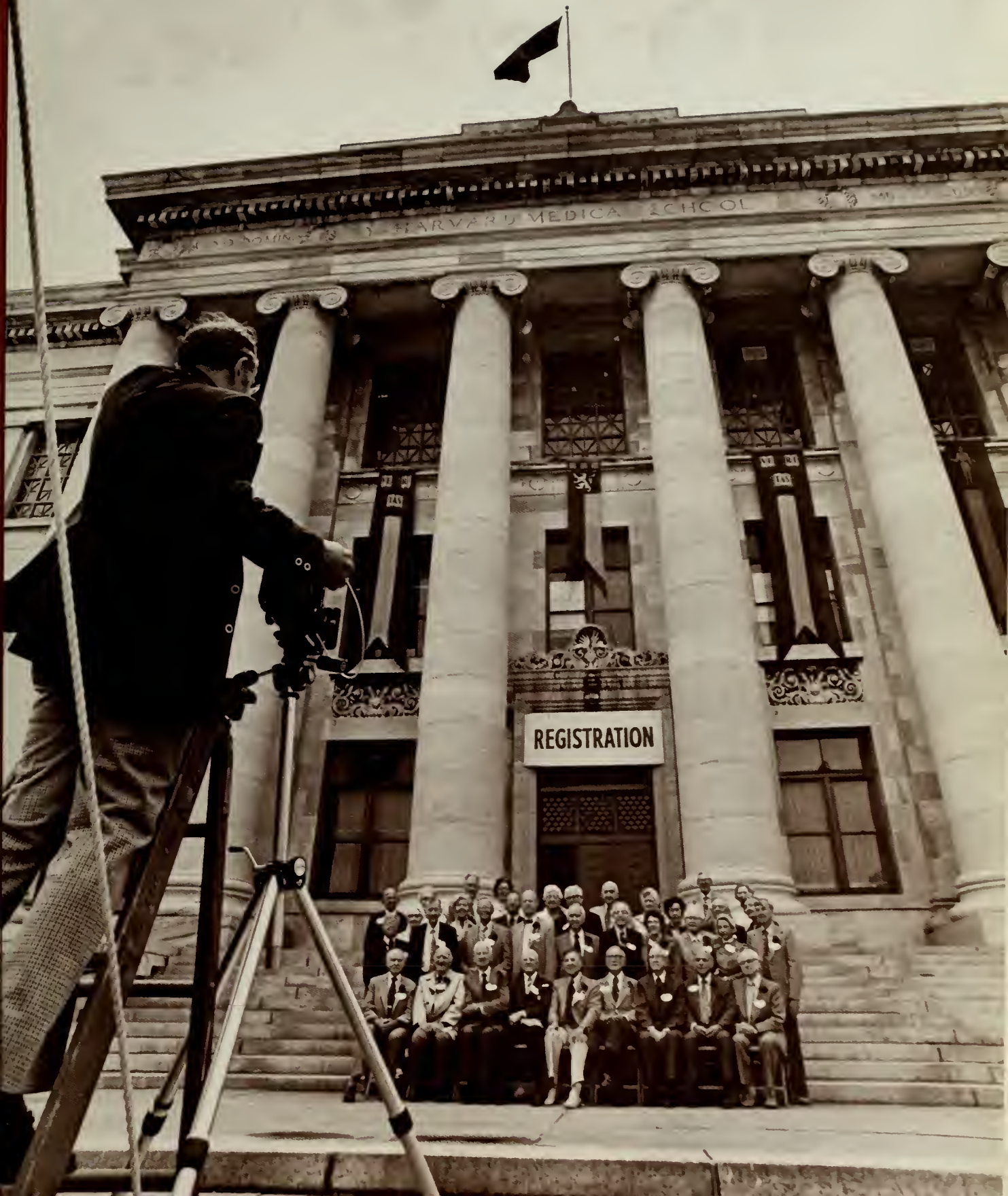


Harvard Medical Alumni Bulletin

July/August 1977



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Harvard Medical Alumni Bulletin

july/ august 1977 vol. 51, no. 6

1976 was a good year for the *Alumni Bulletin*, as we were again singled out for two awards in the 1977 Recognition Program sponsored by the Council for the Advancement and Support of Education. Our November/December poetry collection received an exceptional achievement award, and the cover of the July/August *Alumni Day* issue garnered a citation award for visual design in print. We are gratified that the quality of our work has won the approbation of our colleagues.

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Credits: Cover, pp. 5-11, 13-15, 17-22, 26-27, Bradford Herzog; p. 2, Diane Andronica; pp. 30-35, Melvin Hookailo; p. 48, Massachusetts General Hospital. The Bulletin would also like to thank Nan Goldstein '79 and Jonathan Braun '79, who expressed their yearning towards residency by posing as fourth year students in the May/June HMAB.

Cover: We photographed the fiftieth reunion class of 1927 being photographed on the steps of Building A — an Alumni Day tradition.

Overview

HMS, MIT: a working partnership

Since 1970, when the Harvard-MIT Program in Health Sciences and Technology (HST) was established, the two institutions have worked towards closer collaboration in the training of physicians and other health professionals who can apply modern science and technology to the health needs of society. Now, a new milestone has been reached: an inter-university Division of Health Sciences and Technology has been formally established by the two schools, in order to make available educational and research opportunities that neither institution alone could develop as effectively.

Among the first fruits of the new relationship will be a program in medical engineering and medical physics, leading to a Ph.D. degree at Harvard or MIT, which will be accepting students for the fall of 1978.

The new division will be directed by Irving M. London '43A, who has headed the HST program since its inception. Dr. London is a professor of medicine at both Harvard and MIT and a professor of biology at MIT, as well as serving as a physician on the staff of the Peter Bent Brigham Hospital. Among the university units participating in the Division of Health Sciences and Technology are the Harvard faculties of medicine, public health, arts and sciences, and the division of applied sciences; and the MIT schools of engineering, sciences, humanities and social sciences, architecture and planning, and the Sloan School of Management.

The division will be an integral part of both universities, and will provide a framework for teaching, research and new professions within the health field. It also will facilitate appointment of new faculty and development of new facilities and career opportunities for those committed to working in the field, and provide visible evidence of the importance the two universities attach to the enterprise.

Currently, more than one hundred students are pursuing the HST program, nearly thirty of whom are also candidates for the Ph.D. degree at one of the two schools in a wide range of health-related fields. Another product of the Harvard-MIT collaboration has been the formation of inter-university research teams, which are now working in areas including biomaterials science, rehabilitation engineering, nuclear medicine, radiation therapy, clinical instrumentation, radiopharmaceutical development, and toxicology.

The Class of 1981

Those of us who work in Building A know the telltale signs: overcoats strewn about, doctors converging for closed-door caucusing, the smell of cigarette smoke and crackers-and-cheese hanging heavy in the air. The new admissions season is upon HMS, and the Admission Committee is at work. Into the three and a half months between the November 1 application deadline and the issuing of the February 15 acceptance letters are packed hundreds of meetings and literally thousands of interviews, at HMS and wherever applicants can be assembled.

When this incredible intensity of activity is over and the smoke has cleared, one can sit back and consider the overall characteristics of the group that soon will become part of HMS. F. Sargent Cheever '36, director of admission, did just this in his report to the faculty meeting on June 1.

The Class of 1981, which will take up its work at Harvard Medical School in September 1977 has been selected. The application pool reached a record size; we received 3,861 applications, an increase of approximately 5% over the previous year. Both male and female applications showed an increase of about 5% and both achieved new records: 2,766 and 1,095 respectively. The proportion of women applicants in the application pool was 28%. This percentage has remained the same during the past three years.

One hundred sixty-five students were accepted in the class. Of these, 114 were men and 51 women. These

figures duplicate exactly our experience of a year ago. It is interesting to note that while 28% of the application pool are women, 31% of the class actually matriculating are women. This is a pattern which has obtained now for several years.

The Health Sciences and Technology Program received 450 applications (these figures are included in the total pool); of these 379 were men and 71 women. In the accepted group 19 were men and 6 women.

Of the 165 accepted, 140 register for the regular program at Harvard Medical School and 25 register for the Harvard-MIT Joint Program in the Health Sciences and Technology.

Minority applications (included in the above figures) rose slightly from 499 to 501, establishing a new record. This slight increase is probably due to the fact that we extended the period for the receipt of applications by two weeks at the request of minority groups. In the regular program there are 28 minority students thus giving a percentage figure of 20%. In the HST program there are 2 minority students matriculating, giving a figure of 8%. The HST program has never acquired great popularity with women applicants or with minority applicants, perhaps because of its specialized nature. In general, our minority figures are about the same as last year.

We received applications from all states of the Union and from about 40 foreign countries. New York, California and Massachusetts in that order, produced the most applicants. In the class matriculating, New York leads with 37; followed by California with 24; Massachusetts with 19; New Jersey with 12 and Maryland with 7. There are 5 foreign students in the class; 2 from Canada and 1 each from Hong Kong, Ghana and Trinidad. Several of these students have expressed intent to become US citizens.

Approximately 600 colleges and universities are represented in our application pool. Harvard/Radcliffe has produced the greatest number of applicants, 303; Stanford followed with 121; then Yale with 116; University of California at Berkeley 105; and MIT with

(continued on p. 4)

The face on the Faculty Room wall

On June 30, Dean Robert H. Ebert moved out of the office he occupied for twelve years on the first floor of Building A — but anyone who would like to see the former dean can find him just down the hall in the Faculty Room. He is wearing the blue and scarlet academic gown of Magdalene College, Oxford, where in 1939 he earned a Ph.D., and on the table beside him is the green and yellow hood of his honorary M.D. from Rush Medical College. His expression is benign but — appropriately for a medical school dean — determined and not altogether untroubled.



It is, of course, Dean Ebert's portrait that has taken its place among the venerable visages of deans, founding fathers and faculty that adorn the walls of the Faculty Room (which, by the way, has been renamed the Waterhouse Room). The portrait, which was painted by Peter Pezzati, a Boston artist who also painted former dean George P. Berry, proves that an official portrait can be dignified without being grim. While

remaining in harmony with its historic counterparts, the picture is lighter and more colorful than many of its rather somber neighbors.

The painting may even have helped maintain Dr. Ebert's health during his busy last year of deanship — during the dozen or so sittings at Mr. Pezzati's Ipswich Street studio, he was required

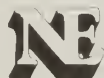
to sit in one place and remain relatively quiescent for at least two hours. A simple ceremony marked the unveiling of the portrait on May 20: Dean Ebert's wife Emily, his daughter Betsy Schmidt-Nowara, and his grandson Christopher did the honors before an audience composed of the tenured faculty, both active and emeriti.

Medicine at Harvard

The First Three Hundred Years
Henry K. Beecher, M.D. and Mark D. Altschule, M.D.



Since 1782 Harvard Medical School has been associated with most of the world's developments in medicine, often either as creator or challenger. This is a generously documented, illustrated account and assessment of Harvard's contribution to medical education and to medical practice. There are no chronologies of names, dates, and discoveries; instead the authors describe the Harvard past so as to reveal the trends leading to significant developments, and to define the ideas that made them possible. The emphasis is upon both the men themselves—in the classroom, in the laboratory, in the hospital—and the medicine they made. \$27.50



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100. In the class matriculating, Harvard/Radcliffe has 38 representatives followed by MIT with 12; Stanford with 11; Yale 8; and Brown, Princeton, and University of California at Berkeley with 4 each.

At least 9 children of faculty applied and 9 were accepted; of the 45 children of alumni who applied, 12 were accepted by HMS, and 12 accepted HMS.

Two transfer students were accepted into the second year class. One is a Rhodes Scholar who gave up his place in the Class of 1979 in order to attend Oxford University. The other individual completed one year of medical school at Baylor successfully and then chose to change to physiology in which he obtained his Ph.D. degree from the University of Delaware. He has been teaching in the department of physiology at HMS for several years and now wishes to complete his clinical training. Two transfer students were accepted into the third year class; one from the University of California at San Francisco whose spouse is starting an internship at the Massachusetts General Hospital and the other from Stanford University School of Medicine whose spouse is starting an internship at the Beth Israel Hospital.

The total number of candidates interviewed reached a new high: 1,321 and the total number of interviews carried out was 2,947. Most of these interviews took place in Boston but a significant number were carried out by our regional interviewers. These figures represent an appreciable increase in the load of the Committee on Admission and is causing us some concern.

The GPA averages of the applicant pool and the matriculating students remain high and have shown no significant change. Similarly the averages for the Medical College Admission Test remain high for the applicant pool as a whole and even higher, as one would expect, for the matriculating class. The average for the science test for the class matriculating is 689, a significant increase over last year.

To date 32 candidates accepted by Harvard Medical School have declined our offer, choosing to attend a medical school elsewhere. Of these, 1/3 (approximately) have given no reason;

approximately 1/3 have stated personal reasons such as the graduate program of the spouse, familial problems; etc., while the remaining third have given financial reasons. Several have chosen to go to state universities because of lower tuition. Another group has chosen to go to institutions providing fully funded scholarship programs for medical scientists (i.e. M.D.-Ph.D. combined programs). The figure of 32 is approximately what we experienced last year. It is surprising that it has remained so low when one considers that tuition has gone up appreciably while available scholarship funds have been reduced.

The six problems still facing the Committee on Admission are:

- 1) The fact that we are drowning in a sea of paperwork.
- 2) The lack of adequate space.
- 3) The ever increasing load of interviewing.
- 4) Our inability to persuade faculty members from the basic science departments to play a role in the admissions process.
- 5) The future role of the minority subcommittee.
- 6) The problem of the socio-economically deprived white applicant.

NCI grant to promote cancer control

The National Cancer Institute has made a grant of nearly three million dollars to be used over the next three years by the Regional Cancer Control Committee and four Boston cancer centers, for the dissemination of up-to-date information and techniques related to cancer. Two Harvard-affiliated centers will receive part of the grant — the Sidney Farber Cancer Institute and the Cox Center at the Massachusetts General Hospital — along with the Boston University Cancer Research Center and the Tufts-New England Medical Center.

The purpose of the project, as explained by Alfred L. Frechette, M.D., chairman of the Regional Cancer Control Committee and principal investigator for the grant, is "to establish programs which will transmit current cancer knowledge and techniques in

the areas of prevention, detection, diagnosis, treatment, rehabilitation, and continuing care to both health professionals and the public. The Regional Cancer Control Committee will promote cooperative relationships among institutions, agencies and community groups involved in cancer control activities. We hope to prevent unnecessary duplications and be able to pinpoint incomplete coverage in providing cancer control programs and services."

Rigler and radiology

This year's *Leaders in American Medicine* film series debuts September 28 at 4:30 at the Countway Library with a program on Leo G. Rigler, M.D., of the Leo G. Rigler Center for Radiological Sciences, UCLA School of Medicine. Discussants will be Harry Mellins, M.D., professor of radiology, HMS; Lloyd Hawes '37, professor of radiology, University of Massachusetts Medical School and Honorary Curator of the Historical Collection in Radiology, Countway Library; and Dr. Rigler.

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Alumni Day 1977

When you don't have a dog, hunt with a cat, or life in the changing world of international health

by Harold H. Royaltey

After a number of years in private practice, Harold H. Royaltey, Jr., '52 returned to UCLA for a master of public health degree in 1969. Since August 1970 he has been associated with Project HOPE, first as deputy chief of staff and chief public health officer of SS HOPE in Jamaica. From 1972 to 1975 he served as chief of staff of SS HOPE in Natal, Brazil, and then transferred to a land-based assignment as director of Project HOPE in Brazil. He currently serves as regional director of Project HOPE in South America, supervising four programs in Brazil, two in Colombia and one in Peru.

In Brazil's Northeast, the poverty pocket of that otherwise booming giant of a nation, there is a saying: "Quando você não tem um cachorro, cace com um gato." Translated, it means, "When you don't have a dog, hunt with a cat." Further translated it means, "Make do." Re-re-translated it means, for example, that another South American country spends about three per cent of its gross national product on health care, which amounts to about fifteen dollars per person per year. Any way you cut it, especially if you're from the US, where by someone's recent guess we spend well over six hundred dollars to do the same job, you must realize that making do is indeed the order of the day.

How can a "gringo" physician, graduate of this University and native of the world's richest nation, find happiness working where the national health budget won't even allow hiring enough hospital housekeepers, let alone color coordinate the ICU? And how can he find it working in an increasingly suspicious third world which has learned to question our widely self-proclaimed altruism and omniscience and which sometimes even chants, "Yankee go home"?

Where are the good old days when Albert Schweitzer, that great good man, could almost singlehandedly set up and run his hospital and health care system



"Governments must not be expected to bow down in gratitude because we are willing to set up an isolated hospital."



and still be inspired to play Bach fugues? What is to become of a new Albert Schweitzer who only wants to start a clinic along the Amazon somewhere and immunize everyone and wipe out disease in his own little corner of the world?

Do we even have any business, really, being involved in international health, which some less than charitable persons have said consists of "sticking our medical noses into other people's medical business" at a time when we haven't exactly solved all the problems of health here in our own country?

I believe the answer is a qualified yes to a participation in international health, but no longer by the Albert Schweitzer approach, or by any other imported purely service oriented one. We have, I hope, finally realized that we cannot, as the old saw has it, empty the ocean with a teaspoon.

But the answer is definitely no to those who think they can work successfully while ignoring local cultural realities and fierce nationalistic pride, or who believe that their local counterparts in patient care are ignorant of medical truth. Somewhere in the works of James Branch Cabell, this interchange occurs:

"... you will pay me the price of one black rooster."

"But what," asked Tenjo, "is a rooster?"

"Why a rooster... is the male of the *Gallus domesticus*."

"We do not call a male chicken that..."

"No," Gerald assented, "no, but you ought to. And not to do so is wholly un-American." I submit that Gerald is not a good man to send abroad these days into the changing world of international health.

Ministries of health and divisions of health planning in South American countries (and I'm sure in others —



Dr. Royalty

though South America is my beat) are looking in an organized way at the health problems of their people. With the requested collaboration of many international agencies, both official (WHO, PAHO) and voluntary, they are producing national health plans that to me are often quite wondrous documents. These plans are usually well directed toward the major problems and suggest reasonable and basic solutions. And yet, they are generally beyond the abilities of the countries to carry out because of the local deficiencies not only of financial resources, but even more so of human and organizational ones. The ministries recognize this and are reaching out to international agencies to help them achieve goals in various critical areas of need.

Usually high in their priorities is the development of preventive and community health services, often centered around maternal and child health programs. In more and more Latin American countries (Peru most recently), these programs are including family planning services. Concerted efforts to regionalize health services from rural or barrio primary care units, through regional hospitals and centers up through the university medical center are being developed, notably in Colombia.



In all this diversity of attack on grave health care deficiencies, there is much stumbling and groping. Babies still die needlessly and mothers go on becoming mothers until they are Gravidas XVIII and even more. Help must be given by competent and determined professionals, not only physicians — although they are needed to guide their counterparts in teaching and organizing better clinical departments — but also by dentists and nurses and allied health people of all types.

The difference today is that governments must not be expected to bow down in gratitude because we are willing to set up an isolated hospital in a remote area. What they want is to attack their problems in a more collaborative way, coordinated with their own long-term national goals. This is the major change from the days of the old missionary hospital giving generally

late-stage care to whomever turned up at the door.

The two ways I have been personally involved in the response to these requests, through Project HOPE, have been in education and implementation. Education in this context implies anything from a one-to-one interchange between a North American radiology professor and his counterpart in a South American university, to training women in rural villages to become *promotoras de salud*, who will work in those villages to educate their neighbors in the rudiments of hygiene and health care. Implementation generally consists in having physicians, and other health professionals with needed skills work with host country counterparts to give an initial boost to a new hospital staff, or a community health plan or even to a rural health post system — always in conformity with the priorities set by the host country itself.

I believe that there is still a place for the would-be Albert Schweitzers of the world. But the world in which they will work has grown in complexity in the quarter of a century since we charged forth from Vanderbilt Hall and the married students' luxury apartments near the Divinity School grounds and other odd corners about the Yard, to save lives and stamp out disease in our several chosen ways. In international health we need good hunters who can help people do so with cats, and when possible help them to learn to do so with dogs.

It is rewarding and meaningful work for the type who yearns for faraway places, loves cultural diversity, and can accept the frustration of not having everything — in fact sometimes having almost nothing — of what we were taught we needed for practicing and teaching good medicine, and who can accept cheerfully that one thing he or she will find as highly developed abroad as in our very own Washington, D.C., is bureaucracy — and whose spouse can enjoy the role of pioneer.

But no rooster lovers named Gerald need apply.

Population, person power and Peru: or the tale of a peregrinating planner

by Thomas L. Hall



Dr. Hall

Thomas L. Hall '57 returned to Harvard in 1961 for a master of public health degree from the School of Public Health, obtaining a doctorate in this field from Johns Hopkins in 1967. One consequence of Dr. Hall's work in international health and population has been the twenty moves he has made in as many years, taking up residence in eight countries. He has directed the Carolina Population Center of the University of North Carolina since 1974, and recently assumed a professorship in the department of health administration, where he will teach and do research in the areas of health manpower planning and population program administration.

I find myself only partway down the road towards attaining true wisdom. As you may know, wisdom is reflected by the exercise of good judgment; good judgment comes from experience; and experience comes from exercising bad judgment. In my primary specialty of health care planning, I feel that my colleagues and I are well on the road to the requisite experience.

I would like to remark on some of the lessons learned during my second career, that of health manpower planner. The scene is Peru in 1963-64; the task, to estimate the supply of and the demand for physicians, dentists, pharmacists, nurses, midwives, auxiliaries, and some five other manpower categories through 1984. Many studies were carried out during the year I was in Peru, but I will comment on only one, the manpower census, which sought to characterize the estimated seventeen thousand persons working in the health sector in 1964. The lessons derived from this census are many — and in large part relate to the US as well.

First, do not entrust a major non-routine assignment to government agencies concerned with routine operations. We sent the census questionnaires through the usual Ministry of Public Health channels and five months later, we had only one-third of the responses expected. At this point we took stock of our situation, hired four physicians and sent them to the four winds for a month to complete the census. They returned with mountains of questionnaires, which, once tabulated, suggested we were still lacking one-third of the health labor force, and showed wide variations according to region. By now lesson

number two had begun to sink in: do not "piggy-back" questions onto the essential data required for the survey. A previous team composed mainly of social scientists had designed the census form, and included quite a few personal questions germane to social scientists that slowed the survey greatly. Once we simplified the questionnaire, we moved on expeditiously.

With only two-thirds of the information in hand, we were faced with a painful choice: go once again to the field, or cash in our chips. After much agonizing, we decided to raise the ante. Thus began one of the most interesting experiments of my life. Four of us — three members of the Peruvian Health Sector Planning Office and I — spent five weeks criss-crossing the country to complete the census. One stayed in Lima, one visited the coastal cities, one traversed the north and the jungle, and I took the highlands, in the Andes. Picture the scene: 2,500 miles in five weeks, eighty per cent over dirt roads at an average speed of eighteen miles per hour in my VW Bug. Many days I would not encounter another moving vehicle. Armed with computer printouts, I went to all of the institutions and communities from Huancayo, at the latitude of Lima, down to Puno on Lake Titicaca and Arequipa in the south.

Let me begin by commenting on some of the nonmedical lessons of this sojourn. The first was a matter of physiology, or testing the limits of my gastrointestinal capabilities. As guest of honor in a tiny Indian village in the highlands of Peru at an elevation of eleven thousand feet, I was presented with a serving of what was said



to be barbecued guinea pig — belly up, complete from teeth to tail — but which looked identical to our common wharf rat. As guest of honor, I could hardly decline to eat this highland delicacy as instructed — like corn on the cob. Except for the psychological aspects, it tasted reasonably good. Then we were all instructed to remove the middle ear — a bone, about a millimeter in diameter — drop it into a glass of pure brandy, and swallow it lest we be visited with bad luck. With a specific gravity similar to that of brandy, the bone clung to the side of the glass no matter whether one downed it with one gulp — a fire eating

experience — slowly, or any other way in between. Refill after refill soon showed me that my luck would be worse if I persisted, especially with the eleven thousand foot altitude as adjunct to the brandy effect, so I consigned myself to the fates. Later on I had occasion to eat a bull's penis on a bed of greens. That didn't faze me at all. But I finally met my limits when the director-general of one health service offered me a live soft-shelled crab crawling across the plate. "Dr. Hall, that's the largest one, for you," he gestured. "After you, sir," I replied.

Another, perhaps slightly medical, lesson can be summarized as getting high with the dogs. During the trip I learned the useful skill of how to tell the altitude without an altimeter. Every morning about 6 a.m. I would leave my hotel nestled in some deep valley, zigzagging my way up for two hours, to cross a high mountain pass, then down two hours, to cross a river, up two hours more, to cross another pass, and then down to my destination. During one of these expeditions it suddenly came to me: all Peru could be divided into seven dog zones. The lowest one was where the dogs chased my car uphill, barking. At



the second zone, they chased the car downhill, barking. The next zones were pretty obvious: they would chase the car uphill without barking, then downhill without barking, then barking without chasing, and in the sixth zone, they would follow the passage of the car with their heads, without barking. It was only in the seventh and highest zone that I had some trouble determining my altitude: for the most part neither the dogs nor I were much aware of the other's presence.

My tour of the mountains gave impressive verification of the problems of health resource allocation. Like other developing countries, Peru's rate of hospitalization and level of hospital development are closer to those of developed countries than is its provision of ambulatory care. As in the US we see constantly the imbalance between ambulatory and inpatient care — too many resources, and too much patient time spent in expensive hospitals where patients are often needlessly admitted, and the emphasis is on repair and not prevention. In countries with scarce resources, disagreeable aspects of ambulatory care practice for the health professions lead to an intolerable situation. As one doctor I talked with put it, "When I'm in the clinic I see a flood of patients without a chance to relate to them, to follow their illnesses, and to get to know them as persons. Even though the numbers I see are far less, at least in the hospital I can get to know my patients slightly during the course of their two to three week stay with us."



Dean Ebert engages Derek Bok, president of Harvard (left), and Perry J. Culver '41, director of alumni relations (right), in a contemplative dialogue.

I also became aware of the hourglass configuration of health manpower, and of its significance for health care. In any complex system requiring many diverse skills one would expect a pyramid of skill levels: a relatively small proportion of highly trained professionals, supported by a larger group of technicians and allied professionals, which in turn is supported by an even larger group of support staff of all types. In Peru the manpower configuration is that of an hourglass, top-heavy with professionals, bottom-heavy with a large number of virtually unskilled aides and auxiliaries, with a pinched waist of nurses, midwives, and technicians.

The schools produce professionals at a faster rate than they can be realistically absorbed by the health economy, and they are then also in a better position politically than most other occupational groups in obliging the government to create jobs for them at higher salary scales. The results of this situation are predictable: relatively few jobs created for the middle level personnel, and a tendency on the part of administrators to use poorly paid, untrained auxiliaries to do much of the work that should normally be assigned to the intermediate category. Since the system does not have the right mix of manpower, and since salaries represent such an inordinately high proportion of the budget that

“Picture the scene:
2,500 miles in five weeks,
eighty per cent over dirt roads at an
average speed of eighteen miles per hour
. . . armed with computer printouts.”



Maxwell Finland '26

they interfere with the ability of the system to provide adequate medicines, facilities, equipment and supplies, the productivity of the professionals is low. The answer to this observed low productivity was obvious to those involved in it: more health workers, particularly more doctors and other high level professionals! There is a demand for care, which the physicians are unable to meet entirely, so the schools and the political authority crank out more of the same. This solution, as I'm sure will be no surprise, has also been a cornerstone of American efforts to correct for the many structural constraints that limit the productivity of our own health care system.

Another lesson began to become apparent during the course of this census and later on in subsequent studies. In the minds of many professionals, their importance is determined by their numbers. We experienced many pressures, both subtle and direct, to inflate or maximize the numbers of those actively working, as well as the estimates of those needed. In some cases I escaped short of being lynched because of my attempts to bring to the attention of the authorities and the professionals themselves some of the hazards of over-producing high level manpower. Most people forget that while it costs a lot to train a physician, maintaining that physician — or other senior health worker — usually equals or exceeds the initial investment. In one country, not Peru, we pointed out that in the midwifery profession, which had long noted the inadequacies of maternal care, the number of midwifery schools had increased from three to eight. We studied the supply of and the demand for mid-

wives, as well as the effect of these new schools. We concluded that in less than a decade there would be one practicing midwife — if there was enough money to pay her — for every forty to fifty deliveries. There would be a horrendous surplus, which, in effect, the economy could not support.

I learned about some of the special challenges of improving health system productivity in developing countries. At one hospital seventeen per cent of the patients did not need hospitalization. But of even more concern was the long delay between the doctor's decision that a patient could go home, and his or her actual discharge. The reason: no clothes available for the patient to go home in, since they had been given to the relatives at the time of admission. We proposed the obvious: leave the clothes at the hospital. The answer: they had done that but the body lice on the clothes of some patients infested the storage areas, and the patients who did not have lice on arrival did so on departure, and subsequently complained to the authorities. Our solution: launder all the clothing in the hospital laundry. The reply: they had done that but the fragile clothing of many patients was ruined by the laundry. Our proposed solution, economically sound but politically untenable: provide all patients with new but inexpensive clothing on discharge, which would be more than compensated by the five or more days of hospitalization saved.

My last lesson from this experience was perhaps the most important, and painful; it involved a trap that virtually all

manpower planners have fallen into, and though I think we managed to avoid it in our study of Chile several years later, the problem remains a threat to most any manpower planning enterprise. The peril: spending much more effort on studying supply than demand. The present and projected supply and demand for health manpower, are co-equal and co-related variables. The manpower planner seeks to form a chain of logic that links the one with the other, and a chain is only as strong as its weakest link. As in most studies, whatever the subject, we tend to spend the most time measuring that which we can measure, or at least approximate. The result of this is often sterile — a shelf document that receives scant attention, or perhaps worse, application of policies affecting supply and demand that are insufficiently documented and unsound. Demand is unquestionably more difficult to contend with than supply, but it is there we must concentrate our best efforts.

Let me conclude by returning briefly to the search for wisdom through experience and to my discovery of a non-barometric altimeter — the seven dog zones of Peru. As we of the Class of 1957 gather here for our twentieth reunion, approximately halfway through — in the jargon of my trade — our “professional worklife,” I believe we are on the threshold of gaining true wisdom as a result of all the experience we have acquired by exercising so much bad judgment. But, by the other standard of the dog zone analogy, as we slowly ascend toward this lofty objective of wisdom, I fear we may soon find ourselves only able to run downhill, without barking.

Why is the world still so wormy?

by Alfred W. Senft

In December 1946, here in Boston, the late Norman Stoll read his famous address entitled "This Wormy World."¹ In this monograph, Dr. Stoll calculated the global prevalence of various helminth infections. According to the figures presented, worms were said to be responsible for more morbidity than any other disease. In considering *Ascaris* in Asia, Stoll made the astounding calculation that the excretion of worm eggs by the Chinese population would total forty-five grams per person a year or about eighteen tons annually! The amount of DNA this represents has not been determined, but surely enough to reach from here to the moon if strung out linearly.

In the past three decades the situation the world over has improved some, but not much. Worms still have an enormous impact on the health of nations and our forbearance in a global assault on their transmission is still remarkable. Consider, for a moment that the greatest single cause of blindness

in the world is onchocerciasis. The "blindness" is really a punctate opacification induced by migration, within the cornea, of microfilaria, those larval progeny of long, coiled nematodes which are entangled, during their copulatory activity, into a subcutaneous tumor. Since these nodules are large and often found on the scalp or shoulders, they can be easily recognized, and excised, using only modest surgical skill, under a local anesthetic. Removal of nodules, if done early in the disease, prevents onchocercal blindness. The causative vector is the black gnat, *Simulium*, not unlike the black flies which inhabit Maine or Eastern Canada in June.

A significant group of infections causes a disabling and certainly disfiguring disease known by its common name, elephantiasis, a term which aptly describes the final stage. The bite of any of forty or more common mosquito species will suffice to transmit the disease. The injured filariae migrate to and mature in the lymphatic system. The pathology is caused essentially by continuous blockade of lymph flow; the resultant damming up of this fluid stretches and distorts the tissue into horrendous disfigurement. In the late stages of elephantiasis, there is neither cure, nor effective palliative surgery.

Schistosomiasis is another malady of enormous impact on the health of the world. People suffer from liver, gut and bladder fibrosis from schistosome eggs deposited by worms that have fully succumbed to a state of perpetual copulation. Perhaps three hundred eggs are produced each day by a female schistosome, whose fertility may last on the

order of thirty years. Thus, she seems to avoid the menopausal state in her eager attempt to keep the complicated life cycle intact. Thirty years ago, there were an estimated 114 million cases; today schistosomiasis affects about 250 million people in the world, or about one out of every twelve persons. It constitutes perhaps the most intractable chronic public health hazard on this planet.

Why do we still have such a wormy world? In every disease which I have mentioned, the causative organism is large — often meters long, if one thinks of a filaria or a tapeworm. The vectors are well-recognized specific species of flies, mosquitos, or snails. Early detection of clinical cases is not extraordinarily difficult, requiring only blood smears, fecal or urine samples, or skin tests.

If these diseases are so easy to recognize, if their vectors and the ecology are known, why is it that so many millions in the world suffer? The answer, simply stated, is that too few people, who are in a position to influence public health practice, care. Or, to put it another way, such tropical diseases are primarily political diseases, which the governments of the world allow. How can one call a medical disorder a "political disease"? It is because, as I view it, these diseases are totally conquerable and eradicable even at the present state of knowledge. In reality there is no shortage of money either. As nations, we have plenty of money to expend for marginal projects. For instance, we admit to the expenditure of some twenty billion dollars to land several astronauts on the moon or to send probes deep

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Dr. Senft

into space. Yet, during the same time frame, the US spent about three million dollars annually on parasitology research, of which only about \$300,000 was involved in research in the areas I have mentioned.

Developing countries in which these diseases constitute a visible threat to public health are, of course, poor and spend even less than does the US. When one looks at social goals of many of the developing countries, however, one sees:

- an international airline, very likely run at a deficit of many millions of dollars per year;
- a public health service whose officers are quite eager to emigrate

William B. Castle '21



“Such tropical diseases are primarily political diseases which the governments of the world allow.”

to the West, and whose minister usually rides in a chauffeur-driven Mercedes-Benz;

- a national research effort which often focuses on the degenerative and mitotic diseases — using sophisticated procedures, imported instruments and supplies, often in a futile attempt to mimic our own National Institutes of Health; and
- a tourist-based luxury hotel system, each equipped with the latest bathroom accessory, staffed by natives who, when the season is over, return to homes which generally have open sewer toilets and no running water. The waiter who serves your broiled scallops probably has children who have hookworm and ascaris infection.
- One also sees in most countries a compulsive growth of armed forces. What do you think that country “X” in Africa buys the most of: drugs for schistosomiasis or filariasis? or bazookas, jeeps, and weapon carriers? Country “Y” in South America: does it purchase helicopters for the doctors and public health workers to go out in the field — or is that helicopter likely to be a military gunship providing security against an imagined external threat?

Recently, after many years of hesitation, the World Health Organization has undertaken to mount a major research and chemotherapy effort for these six principal diseases: malaria, schistosomiasis, filariasis, onchocerciasis, leprosy, and trypanosomiasis. A “major effort” in terms of the WHO budget is about twenty million dollars expended over a three to five year period, or about a million dollars per year per disease. Even though these quantities are extremely modest, when divided by the populations at risk, they do represent a significant impact in this field. Also en-

Dr. Maxwell Finland and Thomas B. Quigley '33





couraging is the promise of the OPEC countries, who are swimming in money, that they will contribute to the goal of improving public health in the impoverished countries of the world.

What could be done to make the world less wormy? Certainly, to begin with, the problem rests with the people themselves, who need to know how to avoid infection. Health awareness and education are the answer. But, since many helminthic infections are acquired by infants and young children, it is not likely that they can practice preventive medicine unless their elders and their governments insist on changing the ecology of disease patterns. In the western world the greatest advance in public health resulted from installing water treatment plants and piped sewage waste systems. In terms of personal sanitation, undoubtedly, Mr. Crapper deserves a posthumous medal for his invention of the flushing toilet. Some wag has said that hookworm in the South was not finally conquered until the advent of competitive gasoline stations, which offered practical lavatory facilities for the traveler as well as gas and oil for the car.

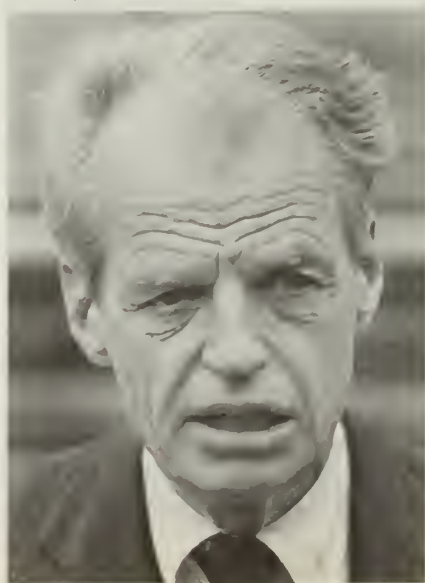
"This right to freedom from debilitating factors (which include parasitic diseases) ought to accrue to every human being."

These accoutrements of civilization are notoriously lacking in at least half of the rest of the world. Since it does not seem likely that piped sewage lines will become available to the vast masses of underprivileged people, there is an urgent need to design and produce viable and sanitary substitutes. Perhaps widespread installation of individual or small group shared fecal-decomposition-methane generators — the *multrum clivus* idea of disposal of human and animal waste — would be pragmatic and helpful. Such systems can be run on small amounts of water, often a precious commodity in the tropics, and produce a valuable byproduct, methane, which could then be used for cooking or running simple refrigeration.

Just thirty-four years ago, the discovery of remarkable anti-arthropod properties of DDT thrilled the medical world. Here was a cheap, effective way to get rid of mosquitos, ticks, and flies. Malaria, filariasis, and typhus would be no more! The intervening years have sobered these expectations. DDT and similar compounds are now virtually banned, and in many developing parts of the world local governments have taken their cue from us and likewise have prohibited the use of other residual insecticides. We face a paradox: we may know what will kill mosquitoes or simuliads, but we dare not use the chemicals because of real or sometimes imagined effects on our ecology. Ergo, malaria and filariasis are again on the rise. Problem-solving in the area of parasitology becomes complicated and demands precise research and specific control measures. Where will the brains come from to grapple with these problems?

In looking at the curricula in medical schools, one can see that since World War II the teaching of tropical medicine and parasitology has steadily declined.² Many physicians have been exposed to only one or two hours of lectures, while the majority have less than ten hours of contact. When only the most superficial consideration of parasitic diseases is possible, is it any wonder that recent medical graduates have trouble identifying even *Ascaris* or *Enterobius* in the stools of their pediatric charges? Furthermore, graduates of medical schools in underdeveloped countries are now so poorly taught in parasitology that they may know very little of hookworm, despite having grown up in ancylostomal regions themselves. Serious inroads towards understanding the physiology of parasites will be made only by attracting the best students to a career in tropical medicine.³

F. Sargent Cheever '36





A simple realization by political leaders of the importance of eradicating parasitic diseases in their people is of crucial importance. That untutored agrarian reformer, Mao Tse Tung, simply decreed that schistosomiasis was to be eliminated from China, which used to have a minimum of fifty million cases of *Schistosoma japonicum* along the Yangtze and other rivers and canals; now a reported residue exists of only about 500,000 old cases. Even if this accomplishment is exaggerated by political rhetoric, it is nevertheless clear that the Chinese, by dint of hard labor and unsophisticated procedures (such as cleaning canals, burying snails, and impounding fecal waste) have substantially rid their domain of this disease. Similarly, government officials are making concerted efforts to evoke an awareness of public health problems in the Philippines and Egypt.

Perhaps we need a universal statement about health that says: "All people who are alive or who are to be born have a right to their own personal health." Such a right ought to be considered on a par with those of educational and economic opportunities. In addition, each nation would have a stated goal of eliminating those chronic infectious diseases causing public health problems within its borders.

If, in our own country, we feel that we have the right to breathe air free of radiation or pollution; if we expect that our own bodies and those of our children will develop and grow normally, then this right to freedom from debilitating factors (which include parasitic diseases) ought to accrue to every human being. We should support as strongly as possible the new activities of the WHO and certain foundations to reach their goal of eliminating the endemic parasitic diseases of the world.

As I drove up to this meeting, I traveled along Interstate 95, a fine six-lane modern highway. What attracted my attention was that for the third time in my memory this roadway was being built. Giant bulldozers are again pushing around rocks; graders are tearing out perfectly placed curbstones. Where there are trees, they are being ripped out so that more landscaping can be done. Where the gutters were smooth and grassy, they are being widened, deepened and repaved with giant culverts. This activity employing hundreds of men, trucks, and huge earthmoving equipment seems symptomatic of our age. Clearly we invent public projects, and finding no useful outlets for our men and machines, we destroy in order to recreate. Although the gas tax cannot be used for projects which would help decaying cities, we can at least create miles of unusable roadside parkland. If the gas guzzler is doomed, at least we can create a bump-free Autobahn for its journey into Valhalla.

Surely, the world at large is still so wormy because, like us, its priorities are out of joint. So, the next time Sadat visits Washington, instead of talking about the delivery of an obsolete Red-eye Missile system, why can't we have Carter ask him, "Say, how's the Bilharziasis eradication project coming along in your country?"

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4. Note: As a group, the Class of 1952 has had a notable interest in the health of less-developed peoples. Some of us have served on Project Hope, others have done post-war reconstructive surgery in Vietnam. Others have gone to Guatemala, Brazil, or the Pacific Islands. Still others have simply always cherished a hope that someone would ask for help in a well-defined project that might give more meaning to our original urge to go into medicine in order to "help people."

What next?

by Cheves McC. Smythe

As Eugene Braunwald writes in his excellent paper on the problems of the middle 1970s department of medicine, life is not only not a bed of roses for the chairman, but, in addition, the descent from power is not much more comfortable.¹ True, one does not have to put up with marathon and numberless committee meetings, administrative trivia, absolutely impossible expectations from much of the environment, and above all, the soul-wearing, unresolvable task-derived conflicts with their accompanying frustrations. It is also true that there is more time for family, outside interests, extra-professional life, and just plain leisure.

But the life support system to which one has become habituated atrophies. There are no longer bright young people at one's beck and call. Secretaries are fewer, less experienced, and not as pretty or well dressed. The appointment calendar empties. The phone rings less frequently. Trips to the airport are rarer and less hurried. The information flow dries up, and one is left with the wrenching realization of being responsible for planning and doing something between nine and five. Withdrawal symptoms can be severe.

Cheves McC. Smythe '47 is, as Dr. Kraus described him, "an internist by trade who got led astray into the design of medical school programs." Dr. Smythe was largely responsible for the development of the new medical school of the University of Texas at Houston, which he served as dean from 1969 to 1975. He has returned to purely academic pursuits as professor of medicine at Houston.

Therefore, when Perry Culver prescribed a brief talk about what ex-deans do, with a catchy title designed as much to amuse as instruct, and somehow related to Dr. Ebert's approaching retirement and the honor we do him this Alumni Day, I remonstrated that he had to be kidding to expect anyone to be amusing about one of the central themes in King Lear. My protest was promptly brushed aside with the assurance that I would do as well as my literate, ironic, and amusing classmate, Howard Spiro, did in last year's essay assigning technological medical care to the young and general care to the elderly.² The first image that flashed to mind was that Culver seemed to be commissioning a sort of serial reissue of a medical de Senectute from the class of 1947, which heretofore I had not imagined to have been around long enough to be expert on the realities of the twilight years.

Until a few years ago, people leaving dean's or chairman's chairs, excepting those few who survived long enough to retire, characteristically went on doing what they had done before. Furthermore, in that time of steady expansion of existing, and mindless proliferation of new medical schools, there was little cause for concern on the part of university administrations over the problems of such definitely disposable, occasionally recyclable, but undoubtedly biodegradable entities. One could always become a vice president of something-or-other, head a department elsewhere, take a government job, organize a new school, or even direct a foundation. Anyway, viewed in the perspective of all of the

other problems universities were having with medical education, there were not embarrassing numbers of such people cluttering up the environment.

However, things are different now. The supply/demand ratio is out of whack vis à vis the creation of new medical schools and new departments, and of ex-deans and ex-chairmen. Most of the worthwhile vice presidencies seem to have been filled by safe, internal candidates. With the government trying to save money, jobs in Washington are not as much fun as they once were. Harvard Medical School types have taken most of the choice foundation jobs, with Chapman and Fitz at Commonwealth, Glaser at Kaiser, Knowles at Rockefeller, and Ebert going to Millbank. Johnson, Macy, and Kellogg are also directed by ex-deans, all of which combine to make the job market a bit tight. Things really began to get bad for administrative "has-beens," or less delicately put, academic deadwood, when one group of department chairmen after another began to discover that it was better not to be a chairman than to be one. This development is leading some of the brighter individuals to realization that it is better yet never to have been one, the obvious conclusion to draw from Braunwald's paper to which I alluded earlier.

The data supporting some of these generalities are partially anecdotal and partially based on data.³⁻⁶ Dr. Marjorie P. Wilson has a treasure trove of material on the career paths of medical academic leaders.⁷ She is on sabbatical working on what I hope will become a book on medical school organization.



Dr. Smythe

Incidentally, she is working in the office of another member of the class of 1947, Dr. Richard Ross, dean at Johns Hopkins. She says that the typical medical school dean comes to the position in the middle to late forties and stays there for five to seven years. He or she often will have served or will subsequently serve in another administrative position for an equivalent time. For chairmen of major departments, the chairmanship comes a little earlier and lasts somewhat longer.

Thus, in 1977, an individual accepting an appointment as dean of a medical school or chairman of a large department in a medical school neither can nor should expect to retire from his or her professional career in that position. Similarly, the university making the appointment can no longer expect that individual to remain in the same position until he or she retires. A university both can and should expect to cope with the problems of how it intends to utilize such individuals' talents when they are no longer in administrative positions. Those occupying or considering accepting such positions will do well to consider this reality as they plan their subsequent careers. This means that the "What Next?" question for this group of successful persons in the academic medical world is not: "What am I going to do with my retirement?" but rather: "What am I going to do with the last years of my career before I retire?"

"More chairmen and deans willingly and even gladly resign than are unwillingly ejected."



As significant as this question may be for the individuals involved, it is even more important for the universities, for a number of reasons, among which is *not* overly solicitous concern for the habilitation, continued support of lifestyle, or semi-retirement while still in harness, of aging, under-utilized professors. However, the universities should be concerned about the reasons good people willingly or unwillingly leave or are skeptical about taking what were once considered choice positions. Second, such people are usually senior and therefore tenured and expensive, and often beyond their most productive years. Third, the turmoil at the top might be seen as symptomatic of some internal malfunction which needs explanation if not investigation.

More chairmen and deans willingly and even gladly resign, than are unwillingly ejected. When one talks with people who have left administrative positions, common and recurrent themes are frustration and a sense of lack of satisfaction in what they were doing. Why?⁸ Paul Lawrence of the Harvard Business School has formulated some ideas about sources of this frustration.^{9,10} He has pointed out that large, multi-purpose organizations, of which the modern medical school is certainly one, have to evolve distinctly different arrangements or alignments of people and procedures to accomplish different tasks. To be effective, such organizations recognize and deal with the necessary differences between tasks, and are able to encourage policies and procedures most helpful to the people responsible for performing each one.



Since the different tasks require different arrangements, different needs emerge, and invariably conflict occurs within the multipurpose organization. It is the function of the administration to manage this conflict. Policies, procedures, and mechanisms that integrate highly differentiated tasks and recognize their inherent differences are indicators of well-managed organizations. Whereas, those which smooth over or deny such legitimate, internal, task-derived conflict detract from the performance of each, and, hence, of the whole organization.

In plainer and more familiar terms, the mammalian organization is capable of very high performance in that it has found ways for a heart to behave like a heart, a liver to behave like a liver, and for neither to have to behave a little like a kidney by being required to make some urine two half-days a week.

The familiar triad of teaching, patient care, and research is an oversimplified under-estimation of the tasks of a medical school. There are different kinds of teaching, each with its own demands, and even more different kinds of patient care. The span of research tasks needs no comment. This formulation does not take into account the enormous energies involved in just keeping the place running from day to day or those necessary to deal with the many forces of the external environment.

There is nothing wrong or unfamiliar with an organization tackling a large number of considerably varied and highly complex tasks. The usual model to deal with these differences was per-

ceived by Adam Smith in his description of eighteenth century pin making — specialization. Producers are expected to produce, salesmen to sell, and distributors to distribute, and their efforts are integrated by a small number of managers. In medical schools these integrative functions are assigned to many integrators called faculty members, each responsible for the management of his or her own output. Yet research, patient care, and teaching are very different tasks, each with its own requirements and organizational implications.

In one of the hospitals in which I work, the attending physician is responsible only for teaching third year students, which can be done well and is a rewarding assignment. In another hospital, I am simultaneously responsible for advising the residents, following the quality of the work of the interns, teaching third year medical students, taking care of patients, and keeping records of sufficient quality to satisfy third-party payers. I do all of these things badly. It is frustrating and anger-inducing. The resulting inevitable task-derived conflict proliferates and occurs at both individual and institutional levels. Yet, we have no mechanisms or even customs for its resolution, but simply perpetuate it by avoiding it, denying it, smoothing it over, or asserting it is necessary and worth the cost.

These phenomena reach their most extreme expression in the tasks assigned department chairmen. In the academic medical system, the job of the chairman is not to integrate three or four different and sometimes incompatible functions toward a series of institutionally defined objectives, but to support each task to attain its own objective. In the usual sense, the chairman does not manage or direct; he copes with a series of internal and external demands; he smooths and balances.¹¹ In a situation where, in the long haul, persuasion and compromise are the most effective tools, administrators in the medical center find they need primarily political skills. Thus, a significant reason for many of the resignations among academic medical leaders is their eventual recognition of the continuum of frustrations produced by unresolved task-derived conflict.

If one elaborates this kind of reasoning in detail, it can be interpreted as an argument to disaggregate the multiple functions now thought to be integrated at the department and individual faculty member levels. No argument is necessary, because that process is already considerably advanced. It manifests itself everywhere. There are endless examples. Some are the emergence of separate units in diagnostic, nuclear, and therapeutic radiology; the increasing separation of the various sub-disciplines of surgery; the development of sections or divisions in internal medicine; the emergence of ambulatory and emergency care units; the escalat-

"A university both can and should expect to cope with the problems of how it intends to utilize such individuals' talents when they are no longer in administrative positions."

ing problems involved in maintaining academic functions in teaching hospitals; the growing number of financially or business trained people in medical schools and university hospitals.

A most significant phenomenon is the appearance and rapid proliferation of the highly productive, vertically integrated, mono-thematic, special research and patient care group. Older models were Cohn's protein laboratory, Enders's virus research unit, or Finland's clinical-pharmacology-of-antibiotics team. Today, there are clinical oncology, immunology, genetics, or neuroscience groups. They are about equal in size and other characteristics to the departments of old, but they operate outside the usual departmental structure. Leadership of these groups is highly prized.

An interesting characteristic of these units is that their existences may be self-limited. They may collapse when the chief moves on, or dry up under the guidance of a less gifted successor, or move *in toto* to another setting, or be rent by some personal or scientific dispute. Alternately, they may become institutionalized and suffer the fate of achieving departmental status. Such groups enhance rather than subtract from the scholarly, creative function of their leaders.

This process is driven by the increasing size, complexity, and diversity of medical school functions. The complexity is demanding new forms, and already has transformed the dean's office. Nostalgically, we accept the demise of the gentlemanly dean who kept afternoon office hours aided only by an elderly spinster. He has been succeeded by various senior administrative officers, who are recognized as executives of major enterprises. There remains a great deal of uncertainty about the optimal qualifications and experience for the job, how people should be trained for it, how they should relate to the rest of the university, and even the best titles for them, but not about the nature of the job itself.

The same acceptance of changed roles does not seem to have happened yet to the chairmanship of today's bronchopulmonary departments.

What is true of the department chairman's role is even truer of our supposedly fixed mode of organization in medical schools. Six or seven basic science and ten or twelve clinical science departments simply do not reflect the reality of what is happening in medical schools, although the special groups alluded to are closer to that reality. If current departmental structure is not obsolete, it is certainly not very flexible or easily adaptable.





Why should cardiology be more or less independent than otolaryngology or neurology? Why aren't nuclear, diagnostic, and therapeutic radiology separable? Are there more or less reasons to have departments of andrology than of gynecology or of geriatrics than pediatrics? We should be concerned not about the number of our departments but about their size, which is very much the reverse of the current preoccupation.

But, who is to keep the peace in the resulting house of many productive groups competing fiercely for available resources? That is what management is all about. The broad outlines of what will probably emerge are already seen in associate deans responsible for one of the general functions of the medical school, such as pre-M.D. education or post-M.D. education, or health services, or finance. Precisely how many of these titled individuals there are will vary from institution to institution, but their numbers should be tightly restricted and their functions clearly delineated. I think they should be given budgetary responsibility and authority. Their efforts, in turn, must be managed or integrated by the senior executive of the medical school, the dean if you will, but with some other title if you prefer.

Thus, the current two-tier level of medical school administration characterized by a dean and his staff and a limited number of fixed large departments is evolving toward a three-tiered system with an unlimited number of academic units responsible primarily for some aspect of teaching or research, and a

second limited number of people responsible for the larger and more general concerns. The third tier is occupied by a senior person who reports to the central administration of the university.

My phraseology reflects mostly the teaching and research functions of the medical school. In the hospital, where service realities might seem to dictate more structure, it will be argued that such flexibility is not predictable enough. However, hospitals are changing even faster than medical schools and seem to be evolving toward an industrial model of organization.

Dr. Ebert's suggestion that we recognize the realities of the university and hospital phases of medical education¹² and restructure our institutions accordingly is a large scale, appropriately broadly conceived statement of essentially the same issues touched upon in more particulate fashion in these remarks. The suggestion that current department organization, including the functions of the department chairman, be modified should not be seen as a call for radical reform. It is merely an observation that bringing forms and roles into conformation with already existing realities will ameliorate the lot of the troubled department chairmanship and will result in possibly a more flexible and adaptable structure for medical schools.

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Under the Tent

Alumni Council election

The results of this year's Alumni Council balloting were officially announced at Alumni Day. Of the 7,000 ballots distributed, 2,610 valid ballots, or nearly forty per cent, were returned and tallied. The new president-elect is William R. Christensen '42. The other candidate, Daniel D. Federman '53 withdrew his name upon his appointment as Dean for Students and Alumni by incoming Dean Tosteson. It was felt that a conflict of interest would be entailed in his assuming offices in both the administration and the alumni council.



Alumni Day Moderator William Kraus '52 was selected for that role because of his "fine, trenchant wit," explained Perry Culver. Dr. Kraus lived up to expectations, brightening the gloomy, wet weather with his gently humorous introductions and his wry analysis of the twenty-fifth reunion class's "fruit-to-root" ratio — i.e., its fertility in both the familial and professional sectors.

As twenty-fifth reunion chairman Merrill Feldman noted, Dr. Kraus traveled to the Alumni Day festivities from his home in a foreign country — Texas. A cardiologist, he conducts a private consultation practice, and is director of the cardiac laboratory and chief of the EKG department at St. Paul Hospital.

Jane G. Schaller '60 is the new vice president, and T. Franklin Williams '50 and Edwin H. Cassem '66 will represent the Sixth (1947-51) and Third (1962-66) Pentads, respectively. Herschel D. Collins '52 has been elected a councillor at large.

The Alumni Association expresses its appreciation for the participation of those nominees who were not elected: Donald N. Sweeny, Jr. '40, Doris Rubin Bennett '49, Joel P. Friedman '66, and Nanette K. Wenger '54.



Outgoing Alumni Council President Alexander H. Bill '39 leads the 83rd Annual Meeting of the Harvard Medical Alumni Association, while other dignitaries, including incoming president Thomas B. Quigley '33 (far right) look on.

New fund honors Ebert

During his last few months as dean, Robert H. Ebert received a variety of accolades — but there is one that will remain not only as a tribute to his accomplishments, but also as a continuing impetus towards better health care. The Robert H. Ebert Fund has been established "as a flexible source of income to be expended at the discretion of future deans of Harvard Medical School to advance clinical teaching as it relates to the delivery of health care."

When the new fund was announced as a complete surprise to Dr. Ebert at the May 9 dinner of the Overseers' visiting committee, over \$300,000 had already been raised. A booklet prepared for that occasion elaborates the fund's purpose in fostering future innovations of the kind for which Dr. Ebert became known during his twelve years as dean:

"The income of the Robert H. Ebert Fund will be directed to the needs of those programs that enhance the clinician's ability to deliver effective health care. It could, for instance, help underwrite the costs of developing academic programs, such as the preceptorships in primary care, which allow medical students to spend a full month with a practicing physician. Or the Fund's income could be directed to the support of medical student education within the framework of the changing ambulatory care programs in the Harvard affiliated hospitals. It could also assist in the evaluation of the quality of existing clinical teaching, helping to provide measures of success and improvement. While focused clearly on clinical teaching and health care delivery, the Fund will allow future deans the latitude to apply its income where the greatest benefits will result.

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"In sum, as Harvard Medical School, under Dean Ebert's leadership, has responded to the national priority for improved health care delivery, new academic-financial needs have emerged. These have centered around the importance of the clinical phase of a physician's training and the necessity of a continuing review of all aspects of that period. It is, therefore, highly appropriate that a Fund in Robert H. Ebert's name will address these needs with a flexibility that will assure its usefulness over time."

Among the Dean's many contributions have been the establishment of the Harvard Community Health Plan; the Center for Community Health and Medical Care, which conducts research towards the formation of public policy; the Harvard-MIT Program in Health Sciences and Technology; and the Health Careers Summer Program for minority undergraduates. The "Ebert Years" saw the development of model neighborhood health centers as part of Harvard teaching hospitals, the reorganization of Cambridge health care services with Cambridge Hospital as a community resource with five outreach centers, the initiation of continuing education programs to meet the needs of ten community hospitals, and the creation of a residency program in primary care.

The initial fund-raising for the Ebert Fund was headed by John P. Merrill '42 and George G. Walker, co-chairmen of the HMS Committee on Resources. President Derek Bok and former President Nathan Pusey are serving as honorary co-chairmen of the Ebert Fund Committee.

An accounting can also be taken of other areas of the Medical School that have prospered during Dean Ebert's tenure. Between 1965 and 1977, twenty-three endowed professorships were created, with four in 1967 and six in 1973 representing the two "biggest" years. Most recently, the Benjamin Castleman Professorship in Pathology has been fully funded.

The physical parameters of the medical area have also continued to expand in the past dozen years. The Harvard Medical School is 401,203 square feet larger than when Dean Ebert commenced his term, and 253,602 square

feet of existing teaching, research, and residential structures have been renovated. The Seeley G. Mudd Building and the Laboratory of Human Reproduction and Reproductive Biology are now both integral components of the HMS skyline. More than twenty-six million dollars was spent for all such construction endeavors completed within this period of time.

Finally, in the realm of fiscal management, the endowment fund principal has nearly doubled in the past twelve years — from \$72,676,073 to \$128,014,406, increasing over one and a half million dollars in this last year. Providently, the ratio of tuition and endowment income to expenses has remained steady at nineteen per cent.

The Alumni Council presented Dr. Ebert with a silver tray engraved on its upper side with his name, and on the underside with the signatures of all those who served on the Council during his tenure. The Dean's reaction, according to those present, hovered between laughter and tears.



Alumni Association aims

At its February 1977 meeting, the Alumni Council accepted the statement of purpose formulated by an ad hoc committee.

1. The Association should serve as a link between the School and the graduates. It should keep the graduates informed of the activities being carried on within the School. This may be done in a large part through the *Harvard Medical Alumni Bulletin*.

Further fostering of the link between the School and its graduates should be carried out through local Harvard Medical alumni groups in various parts of the country. Meetings of these groups should be fostered by the central office. When possible, such meetings should be centered around the presence of faculty from the School.

2. The Association should serve as a link for continuing service of the alumni to the School. The alumni across the country may serve various functions, such as identifying prospects for admission, interviewing candidates for admission, serving as intermediaries for young graduates who are seeking postgraduate training, and helping with solicitation of funds.

3. Through its activities, the Association should serve in the best interests of the undergraduate and postgraduate student body, who will in due course become members of the Alumni Association.

Through the Alumni Survey Committee, such subjects as admissions policy, the entire area of the undergraduate teaching program, and matters of personal welfare of the students may be investigated. The Survey Committee, through the Council, should make appropriate recommendations to the administration.

The Alumni Association and its Survey Committee should stand ready to study and make recommendations on other problems relating to the Medical School, on request of the Dean or when identified because of the concern on the part of the Alumni Association.

4. The alumni should actively seek the inclusion of the Harvard Medical faculty and those who are or have been in postgraduate training programs at the Medical School, as members of the Association.

5. The Alumni Association should participate actively in the raising of funds for the School from among its membership.

"We have accomplished a lot in the Ebert years"

Perhaps the most important thing that a dean of a medical school must do is to take advantage of the perspective and breadth of vision that the office provides him, in order to survey the profession and its relationship to society in a wider focus than is possible for most of the individuals who work within the school. His role, in short, is to try to reconcile creatively the desires, aspirations, and attitudes of those within the institution — who are always somewhat skeptical of reform and resistant to change — with the pressures of the larger society outside, which continually identifies new problems but is not always very wise in providing solutions and not very patient in waiting for change.

Certainly there have been very few periods in the history of the Medical School that have exhibited such tension and conflict between the larger society and the medical profession as have the last dozen years. In fact, the state of the feelings of the larger society about medicine remind me a little bit of a story told in a recent Woody Allen movie. A patient says, to his analyst, "There's nothing the matter with me. It's my brother who really has the problem. He actually believes that he's a chicken." "Goodness," replies the psychiatrist, "why don't you try to have him committed?" "Oh, no," says he, "I couldn't possibly do that. I really need the eggs."

In much the same way, society sometimes seems to view those in the medical profession as rather eccentric, a bit threatening, and perhaps in need of containment. At the same time, society is also very much aware of how it needs what the doctor can deliver. To try and cope in such a precarious environment is always difficult. I think we can feel particularly fortunate to have had a dean who has neither been so insensitive as to be unaware of some of the more valid, deeper messages that society has communicated, nor so unwise as to jump on the innumerable bandwagons that have come careening by in the last few years with quick fixes and easy nostrums for solving difficult problems.

Despite having to cope with the almost unmanageable complex of institutions, hospitals, laboratories and other enterprises that make up this enormous Medical School, amid a seemingly unrelenting series of pressures from students, government agencies, and community groups, he has made time as well to build some important and enduring monuments. I am thinking, in particular, of the very successful Harvard-MIT Program, which provides the first and most impressive model to show how two great neighboring universities can cooperate in teaching and research. We also have the Harvard Community Health Plan, very much his creation, which stands as a much more realistic and eloquent response to the problems of providing efficient delivery of health services than many of the theoretical articles or blueprints that are proposed for dealing with these complex issues. There are other projects, started later in his career and not yet finished, for which he has laid the foundations upon which others can build in order to resolve the significant prob-

lems facing the School. I refer to the Harvard Medical Center, which provides a forum whereby our many teaching hospitals, if they choose, can plan cooperatively for meeting the numerous demands made by society for medical care. At the Medical School itself, the Division of Primary Care also provides a framework for bringing together people from many different disciplines to undertake a creative program for first defining and then preparing young medical students for this important calling. The Division of Social and Preventive Medicine provides a structure for linking the quantitative and social sciences to the clinical work done in hospitals in order to aid the decision-making process that takes place within those settings.

We really have accomplished quite a lot in the Ebert years, and it is all the more remarkable that these efforts were achieved during a time of turbulence when so many demands were made, so many problems raised, and so many insistent groups clamored for the dean's attention.

To mark this occasion, I would like to announce the creation of the Robert H. Ebert Fund, which will serve as a source of flexible income to support projects relating to clinical teaching for the delivery of health care. The fund to date has attracted over two hundred donors who have given \$322,000 through the help and leadership of Mr. George Walker and Dr. John Merrill. As honorary chairman of this effort and a very dear friend and longtime admirer of Bob, I am especially grateful to all who have contributed to this fund, which speaks so eloquently for the many people who share an affection for Bob Ebert and an admiration for what he has done.

"Can the Medical School innovate?"

Recently I listened to an interview with Bert Lance, the new director of the Bureau of Management and Budget, and he quoted the saying of a Georgia farmer — "If it ain't broke, don't fix it." Lance thought it possible that this principle might even apply to government some day. It is an interesting thought and it fits rather well with what I have to say.

Rather than indulge in a nostalgic journey into the past, I would prefer to ask the question — How responsive is the Harvard Medical School to change? We have concluded a decade of change and there will continue to be significant changes in the decade ahead. Is the organization of the Medical School and its affiliated hospitals one which needs drastic overhauling or can it adjust to new demands and new regulations? Is it an organization more or less responsive than those of other medical schools?

Harvard has a rather different structure than most other universities, and the Medical School, in turn, differs from most medical schools in its organization. Let me review briefly some of these differences so that we can examine whether they make Harvard more flexible or more rigid than other institutions of higher learning.

All of you are familiar with the phrase "every tub on its own bottom," which means that a significant amount of responsibility and authority is delegated to the individual faculties and schools. Central to this concept is the fiscal responsibility of each faculty. If the Medical School wishes to expand its programs and needs more money, it must raise the money itself, for the University does not contribute to the budget of the Medical School apart from those endowment funds which have been designated for the Medical School and the tuition which is paid by medical students. None of this should be interpreted as meaning that Harvard is simply a federation of faculties with little central control; Harvard actually has a strong central administration. The President and Fellows of Harvard College represent a remarkably effective amalgam of what in other universities would be regarded as the central administration of the university and the executive committee of the board of trustees.

Harvard delegates a great deal of responsibility and authority to its faculties, but retains the ultimate authority over budget and appointments as well as the power to tax for the support of overall university functions. These are very considerable powers.

How well does it work? In my view it works remarkably well. Although some things are more difficult to accomplish because of the relative autonomy of the various faculties, by and large it is an organization which is responsive to change. One reason it works so well is the direct working relationship between the deans and the president on all academic matters.

In this brief review I have not mentioned the Board of Overseers, which is a unique organization having many of the functions of a board of trustees, but with members who, rather than being appointed, are elected by a vote of the alumni. One of its most important functions is to appoint committees to visit the various departments of the university. While it is not always clear what the precise relationship is between the two governing boards — namely, the Corporation and the Board of Overseers, it appears to me to be a responsive organization that meets all the needs of the Medical School.

The majority of American medical schools either own and/or operate a university hospital, or have a special relationship with a private hospital that is designated as *the* university hospital. A variant is the so-called medical center with a presiding vice president and a potpourri of institutions including various hospitals, nursing schools, schools for allied health professions, and so on. Whatever its organization, one general hospital is usually dominant and controls the academic appointments in the other hospitals of the medical center.

For historical reasons Harvard has never designated any of its affiliated hospitals *the* university hospital, but over the years has fostered the development of equals. This has obviously worked well in the past — HMS has far greater depth in its clinical faculty than any other medical school in the country — or, indeed, the world. Competition among the teaching hospitals has clearly encouraged the development of multiple centers of excellence. But does this arrangement remain the most desirable organization and can it be responsive to future needs? I believe it can.

The hospitals affiliated with Harvard have another unique quality. All of them start with the proposition that the care of the patient is their primary purpose and that teaching and research are secondary. This might appear to pose a problem for the University, but in fact it is an asset; a hospital dedicated to the care of the patient provides the very best teaching environment for students and house staff.

Three things make the organization of the Harvard Faculty of Medicine different from most other medical schools, and they are interrelated. The first of these is a structure that permits multiple departments within a single clinical discipline. There are, for example, multiple departments of medicine, surgery, psychiatry, and neurology. This has great significance because it means that no head of a clinical service in one teaching hospital is automatically the head of all other hospital departments in the same discipline, and it means that we can attract the very best people for all the clinical services.

The second difference is the governance of the faculty. In many medical schools the executive faculty consists of the heads of all medical school departments, and this means there is usually a jealously guarded balance of power between the clinical and preclinical departments. There is no such executive committee at HMS and instead there is an elected faculty council which acts as the executive arm of the faculty. This is a relatively recent change in organization and replaces an appointed administrative board, but the elected body continues the tradition that department heads do not *ex officio* form the executive body of the faculty.

There is a third difference of importance and that is that the Faculty of Medicine includes all of the faculty of the School of Dental Medicine. The fact that the business of the faculty is for the most part carried out by standing committees and ad hoc committees rather than a tightly organized executive committee of department chairmen facilitates this relationship.

Finally Harvard differs from most medical schools in the sharp separation of functions between the affiliated hospitals and the Medical School. The Medical School is not involved in the operation of any of the hospitals or caring institutions with which it is affiliated and bears no responsibility for any of the operating costs of the hospitals. By the same token the Medical School makes no claim on any professional fees collected by the clinical services in the teaching hospitals. Obviously, these fees contribute to the support of the clinical services, but they are administered entirely at the discretion of the individual hospitals. This is important because today professional fees represent twenty-five per cent of the total support of all American medical schools.

It is tempting to look on professional fees as another way to support the medical school directly rather than indirectly and to tax this source of funds, as is done in many medical schools. The temptation is lessened, however, if coupled with some fiscal responsibility for the cost of patient care. In my view, whatever happens to the professional fees collected by clinical services, they must be tied to the overall welfare of the hospital, for this in the long term will benefit the Medical School more, rather than any direct sharing of these funds.

It is evident that the particular structure of the University and the Medical School has been effective in building a strong faculty and a strong research and teaching institution, but is it responsive to change? In other words, can the Medical School innovate? I believe it can and will give three examples to illustrate the point.

1. *HCHP*. When I was in Cleveland in the late '50s and early '60s, I became interested in prepaid medical care. The meat cutters union wished to develop a plan and invited a number of consultants to help with the development of a prepaid group practice. The consultants included Avram Yedidia, one of the architects of the Kaiser Permanente plan; Richard Weisner, also from Kaiser but subsequently to become the head of social medicine at Yale; and William Stewart, who later became surgeon general of the United States Public Health Service. These knowledgeable men introduced me to the concept of

prepaid medical care. Finding the concept attractive, I sought to interest the Western Reserve Medical School and the University Hospital in forming a direct affiliation with this plan. It seemed an exciting idea for a medical school that had recently revamped its curriculum, so that students would, among other things, be more interested in primary care.

The idea bombed because it threatened some of the vested interests at University Hospital and because it seemed too radical a move. Western Reserve and University Hospital were very sensitive to what other people might think. Curiously, it never occurred to anyone to go to another of the hospitals associated with Western Reserve because University Hospital was *the* teaching hospital, with an interlocking board of trustees with the university. In other words it dominated the clinical scene.

I will not relate the history of the Harvard Community Health Plan except to say that it was possible to develop a prepaid plan at Harvard under far more difficult circumstances than existed at Western Reserve. Here we had to start from scratch, but it was do-able because Harvard's organization is flexible enough to tolerate change. There were multiple teaching hospitals to which we could turn, rather than a single university hospital which could veto the idea. We could do it because we knew how to develop an independent corporate structure separated from the Medical School which then could assume direct responsibilities for the plan. We could do it because Harvard believes in delegating responsibility to its deans. And finally, whatever faults Harvard may have, timidity is not among them. We could do it because no one at Harvard was afraid of what others might think.

2. *HST*. A second example of the ability to innovate is the Harvard-MIT Program in Health Sciences and Technology, which now has become an inter-university division. It is not easy to put together a program that assumes responsibility for one hundred medical students, a large research program, and a Ph.D. program for graduate engineers, which is jointly sponsored by two major universities and involves the faculty of multiple teaching hospitals.

Yet it was possible partly because we are not too highly structured. The Medical School has had considerable experience in forming relationships with other autonomous institutions and had no great difficulty in developing a close working relationship with MIT once it was clear that we had complementary needs and resources. The very fact that we are not tightly bound to one teaching hospital and not tightly controlled by an executive committee makes it easier to innovate.

3. *Neurobiology.* A third example of the Medical School's ability to respond to a unique opportunity is the creation of the department of neurobiology. A group of remarkably creative young neurobiologists was brought together by Dr. Stephen Kuffler in the department of pharmacology. He knew that without a new department the group would soon disperse and this unusual opportunity would be lost. It was not so much the need of money and space that was the issue but rather the need for an identity, and it was possible to give the group that identity by creating a new department. The department of neurobiology is now generally considered to be one of the most distinguished, if not the most distinguished, in the country. It was possible to create a new department, because there was no executive committee composed of department chairmen who would worry about a balance of power. Similarly, it was possible to create departments of anesthesia and radiation therapy when the need arose, and both have attained great distinction.

It would be a great mistake, however, to think that Harvard's particular organization makes everything easier. Anyone familiar with the University knows that this is not the case. The principle of every tub on its own bottom lends itself more to creative competition than to docile cooperation. Similarly, the policy of affiliation with multiple autonomous teaching hospitals does not automatically lead to interhospital cooperation. Let me give some examples of the kinds of problems that are created by Harvard's structure.



Mr. Bok

1. There are three separate and distinct groups of biological scientists in the three different faculties and until recently they had no formal relationship to one another. The Faculty of Medicine, the Faculty of Arts and Sciences, and the School of Public Health each has its own departments in the biological sciences, and each faculty plans its departments on the basis of its own needs without considering the needs of the other schools and faculties. President Bok has been concerned about the problem of joint planning and resources in the biological sciences and has enlisted the aid of Konrad Bloch to chair a joint committee representing the three faculties and to identify areas of possible cooperation. But progress is slow precisely because each faculty is accustomed to its own autonomy. On the other hand, an ultimate solution arrived at by negotiation among equals is likely to be more durable than one imposed by a central authority.

2. There is little doubt that more money is raised from the private sector as a result of a decentralized fund raising effort than could be raised by a single university development office. There is also little doubt that private donors and particularly foundations are sometimes puzzled by simultaneous requests from several Harvard faculties for essentially the same project. It is not uncommon for a foundation to ask Harvard to get its act together before returning with a new proposal.



Dr. Ebert

3. The Affiliated Hospitals Center is now a reality and many of you have passed the huge hole in the ground that represents the beginning of the new hospital complex. But it wasn't easy and it took more than a decade and a half to arrive where we are today. It wasn't easy to merge three hospitals, each jealous of its own autonomy, and it wasn't easy to develop a mechanism for trustees, hospital directors, and service chiefs to work together toward a common goal. The building of a new hospital was opposed by well-organized elements in the local community and the need to face a common opponent probably hastened the actual merger of the Peter Bent Brigham Hospital, the Boston Hospital for Women and the Robert Breck Brigham Hospital.

How well are we structured to face the future? Are we prepared to respond to increasing regulation, to decreasing funding for research, to cost control of hospitals, to control of the number and distribution of residencies among the various specialties, to the demand for more primary care physicians, and to the need to control on some planned basis the introduction of new and expensive technologies? Is our present structure obsolete and in need of drastic revision or is it fundamentally sound?



Dr. Tosteson

Daniel C. Tosteson

Dean, Harvard Medical School

"A community of physician- scholars"

I believe it is fundamentally sound and can adjust to the need for change by developing a number of umbrella organizations that attempt to coordinate but not to dominate the various independent units that make up the University and its affiliated institutions. Let me give some examples.

For a variety of reasons it was desirable to develop strong residency programs in primary care. Rather than develop a new department or encourage each hospital to develop its own completely autonomous program, we created something called the Division of Primary Care, which will coordinate the various hospital programs. The Division will, among other functions, exercise some control over fund-raising in this area, so that we can coordinate our proposals to public and private agencies.

Another example is the Harvard Medical Center. This is a corporate structure consisting originally of the Medical School, the Massachusetts General Hospital, the Massachusetts Eye and Ear Infirmary, the Beth Israel Hospital, the Children's Hospital Medical Center, the Boston Hospital for Women, and the Peter Bent Brigham Hospital. It was formed to coordinate fund-raising but

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For a few minutes I will share with you some thoughts about the history of the Harvard Medical School, particularly the Ebert years, about the idea of the Harvard Medical School as a community of physician-scholars, and about the particular context in which this community — our community — will exist during the years ahead.

The Harvard Medical School stands today with pride upon the traditions of high scholarship and concerned professional service created by those who have worked here before us. No small part of this tradition was built during the twelve years since Bob Ebert became dean. I will not attempt to chronicle now in detail the many accomplishments which occurred during his administration. But I must note that he was concerned about the role of medical schools in educating physicians for primary care long before it became fashionable. The Harvard Community Health Plan is a fitting and enduring expression of Bob's concept of the proper role of a medical school in relation to the community which it serves. Through Bob's imaginative and vigorous leadership, HMS set an example in this field for the nation and the world. Equally impressive is the skill with which he worked with his colleagues in the faculty and in the community to encourage the joining together of the

Peter Bent Brigham Hospital, the Robert Breck Brigham Hospital, and the Boston Hospital for Women to form the Affiliated Hospitals Center. Much rhetoric has been directed toward the issue of cost-effective allocation of medical service resources. The formation of the Affiliated is one of the few constructive acts in this direction of which I know. Bob's efforts were by no means limited to the clinical aspects of the School. To cite but one example, he encouraged the beginning and has consistently nurtured a superb program of scholarly work in neurobiology.

Because of these and many other works too numerous to mention now, HMS owes much to Bob Ebert. In my view, we owe him the most for his presence among us. He is an intelligent, perceptive, honest and kind person. Those who have had the good fortune to work with him know that he deserves their trust. I want you all to know that he has been extraordinarily courteous and helpful to me during this transition. Bob's wife, Emily Ebert, with her wit, dignity and grace, has added further distinction to the Ebert years.

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has now been reorganized to coordinate planning among Harvard associated hospitals. Each hospital is represented by the chairman of its Board of Trustees and the general director; the president of the University and the dean of the Faculty of Medicine represent Harvard with the dean, *ex officio*, acting as the president of the Medical Center. New members have been added including the AHC, the New England Deaconess Hospital, the Sidney Farber Cancer Institute and the Mount Auburn Hospital. The Harvard Medical Center has recently formed three committees to develop procedures for (1) reviewing the various residency programs in Harvard affiliated hospitals, (2) evaluating new (and old) technologies used in the teaching hospitals and (3) developing an approach to joint planning.

It is far too early to tell what will come of this, but I am optimistic. All of the institutions involved are characterized by a kind of pragmatic idealism. They will ultimately try to do the best they can with what is possible, and if doing the best they can means a greater degree of cooperation, then they will plan together. But planning together does not mean a radical change in the present organization. It is possible to retain autonomy and still plan together, and I suspect that is what will happen.

To the aphorism — "If it ain't broke, don't fix it" might be added — if you need new headlights, don't rebuild the motor. In my view, Harvard's motor is fundamentally sound.

Dr. Tosteson

We know that the foundation world will benefit as much as the world of medical education from Bob Ebert's creative efforts. Our regret at his departure is assuaged by the knowledge that he will always be one of us, a member of the Harvard Medical School community. I am happy that he has agreed to serve on the Resources Committee of the Medical School. His acceptance of President Bok's invitation to work with John Dunlop during the coming months to develop a configuration for health policy research and education at Harvard is important not only to the faculty of medicine but to all the faculties of Harvard University. Aside from these particular tasks, Bob Ebert will always be a member of the Harvard Medical School community because he has been here with us. It is this bond which joins together all of us in the community, no matter where we now live and work.

What brought us here and what has made the experience of lasting importance to each of us? We came here to learn medicine, of course. But what did we learn then that we now know and use in our work? Is it what we learned about the pathophysiology of congestive heart failure and the management of peptic ulcer? Or is it *who* we came to know and how those knowings influenced our attitudes about what and how to learn? For most of us, I suspect, more the latter than the former. We came to know our classmates and a few of our teachers in ways which encouraged each of us to continue to learn medicine in our own way, for our own purposes — to become, in short, physician-scholars. This is the essence of medical education. Learning is, by and large, a lonely effort. We come together to learn for encouragement, for criticism, for help in making this continuing effort. The Harvard Medical School has always sought to be a place for this kind of coming together. It is now our turn to carry forward this tradition into the context of the 1980s.

Changing conditions demand changing forms for educating men and women to become physician-scholars. What are some of the changing conditions which will make the medicine of the 1980s different from the medicine of earlier years? In my opinion, medicine in the future will be deeper and broader, more specialized and more integrated, more powerful and more subtle. These developments reflect two complementary trends. First, inter-diffusion of medicine with the physical and biological sciences illuminates with ever greater clarity the components of the components of the components of the human body. Second, through the inter-diffusion of medicine with the social sciences and the humanities, we become increasingly aware of the essential connections between all components to form a single human being, who is in turn a component of social groups. Human health and disease can be understood neither in terms of the properties of the components of which we are composed nor in terms of the social entities which we comprise, but rather in terms of the entire hierarchy.

Let me be more specific. Lithium is the third lightest element. When placed in water, it forms a positively-charged ion similar in many respects to the more common sodium and potassium ions. Lithium competes with sodium and potassium ions for binding and transport across the membranes surrounding the cells comprising the human body. The presence of relatively small amounts of lithium in body fluids of persons suffering from mania dramatically returns the abnormal mood state toward normal. Furthermore, prophylactic administration of the salt markedly reduces the incidence of manic or depressive episodes in persons suffering from so-called bipolar disorders. The onset of such abnormal mood states can also be correlated, in some cases, with the social experiences encountered by the afflicted person. The availability of lithium for treatment and prevention markedly reduces the duration of hospitalization and other economic and social costs associated with these unusual forms of behavior.

Lithium transport across the red cell membranes of human subjects is under genetic control and can vary from individual to individual. In seeking to understand the pathogenesis of abnormal mood states, it would be helpful to know about the relation between the distribution of the genes controlling lithium transport across cell membranes and the incidence of mania. Such studies will require blood from many normal volunteers who must give informed consent. Persons suffering from acute mania sometimes refuse to consent to lithium treatment even when informed. Where in all this does medicine end and physics or chemistry or biology or psychology or sociology or economics or the law or ethics begin?

What do these changing conditions mean for the future of the Harvard Medical School? We must, I think, become both deeper and broader. We must explore ever more deeply the interfaces between medicine and biology, physics and chemistry; we must celebrate these adventures of the human mind. We must show how such insights provide the basis for an effective preventive and therapeutic medicine. At the same time, we must increasingly assume our proper responsibility for assuring that the benefits of scientific medicine are made available to particular persons in particular social situations in ways which assure health in that context. We must work effectively at the interfaces between medicine and the social sciences and humanities and the law.

These goals pose important questions for the future of medical education. We know far more about medicine now than when I was a medical student thirty years ago. By we, I mean the entire community of physicians and health scholars. I know no more, probably less, than I knew then. What I do know is different and reflects my changing interests. This disparity between the mental capacities of we and me, between group and individual, has reached crisis proportions in medicine — a crisis which, I believe, has been insufficiently acknowledged and addressed by medical educators. Despite protestations to the contrary, in

large part we still proceed in medical education according to the implicit assumption that it is appropriate, desirable and necessary that all physicians carry in their heads the knowledge required to deal with all the professional situations they encounter.

This continuing attempt to transfer massive amounts of information into the minds of medical students is destructive to true education in two important respects. First, it diverts the attention of students from the essential task of learning how to exist in a setting in which there will always be far more relevant knowledge than they can possibly store. Deciding what we need to know, and finding an effective style of learning it, must always be our educational goals. There are significant new conceptual and technical approaches to this problem of the management and effective use of information, to which we need to give more attention. But, even more important in my view, is the destructive effect of preoccupation with assimilation of information on the emotional, the human elements of medical education — on the opportunities for students and faculty to engage in meaningful scholarly work together. It is such human transactions which nurture the most fundamental roots of learning, the desire and will to learn. With these, anything is possible; without them, nothing. We medical educators seem continually to forget that it is very difficult to prevent a person who wants to learn something from learning it. Censorship has almost always been a losing game.

These concerns about the process of medical education are not new. Consider the reflections of Claude Bernard in his monograph, "An Introduction to the Study of Experimental Medicine." "I believe, in a word, that the true scientific method confines the mind without suffocating it, leaves it as far as possible face to face with itself, and guides it, while respecting the creative originality and the spontaneity which are its most precious qualities. Science goes for-

ward only through new ideas and through creative original power of thought. In education we must, therefore, take care that knowledge which should arm the mind does not overwhelm it by its weight, and that rules, intended to support the weak parts of the mind, do not atrophy the strong and fertile parts." Or hear Walter Bradford Cannon as a medical student in 1900: "With present methods of instruction, skill in logical thinking, which makes of knowledge a power, is not infrequently sacrificed or impaired by the strained effort of accumulating the very knowledge to be used." I invite each of you to think with me about how we can make education at the Harvard Medical School more creative and fertile.

The words carved on Building D remind us that medicine has always faced an impossible task. "Life is short, the art is long, occasion instant and experiment perilous." In some sense, we chose medicine because it contends directly with the most impossible dimensions of the human condition. Emily Dickinson caught our stance — "Earth is short, and anguish absolute, and many hurt. But what of that." Medicine is not omnipotent, but it is no longer powerless. There is much that we can, should, and must do to ease the burden of human illness. The Harvard Medical School has great resources and great responsibilities to participate in this effort. I am hard at work building an administrative group for this endeavor. One member of the group will be Daniel Federman '53, who has accepted my invitation to serve as Dean for Students and Alumni. One of his responsibilities will be to work with the Alumni Association. Another member of the group will be Henry Meadow, who has agreed to serve as Dean for Finance and Business. I hope that you will join me, members of that group, students and faculty, as we make the next few chapters in the saga of our alma mater.

Reunion Reports



1917

The Class of 1917 had a reunion dinner on Thursday, June 9, at the Harvard Club. Among those present were Joe Wearn, Denny Adams, Monroe McIves, and Lawrence Chaffin. Arlie Bock also dined with us and was elected an honorary member of the class of '17, since he seemed to have misplaced his own Class of '15. There was a lively conversation regarding what has been happening at the Medical School. We all agreed that we could not understand most of the scientific sessions, for they were beyond our mental capacity to appreciate the "ultra-modern" medicine of today. We adjourned late that night, with the hope of again meeting next year.

M. H. Lurie



1927

In certain ways the fiftieth reunion of the class of 1927 was the best we have had. The twenty-seven members and twenty-one wives in attendance (some from long distances) found themselves, more than ever, to be a closely-knit group with an amazing degree of agility, both mental and physical. They obviously enjoyed each other's company thoroughly.

A goodly number of the class joined the many alumni who attended the excellent scientific session held on Thursday, June 2. The speakers had been well chosen for their ability to present complicated subjects in interesting and understandable fashion. Besides, we received "Brownie points" toward helping us stay in practice!

The Friday morning program was enjoyable despite the chilly, rainy weather. Not only were we informed regarding world health problems but we also had the opportunity of seeing and hearing President Bok, retiring Dean Ebert, and Dean-designate Tosteson.

At The Country Club in Brookline on Friday evening, classmates and wives were joined by guests for a total of about fifty-five persons. Guests included Dean and Mrs. Robert H. Ebert and Dr. Perry J. Culver, director of alumni relations. Among other honored guests were Mrs. Dorothy (John C.) Eckels and Mrs. Dorothy (Richard H.) Wallace as well as members of the staff of the alumni office. Special thanks are due to Miss Judy Walsh who did so much in helping make arrangements for the reunion activities.

Informality was the order of the day not only during the reception, which was filled with lively talk, but also during the dinner with no head table and no formal speeches. Lang Parsons displayed his usual skill as toastmaster and raconteur. Dean Ebert spoke of changing attitudes of students and Perry Culver told us of alumni activities. Good conversation, good food and drink, and pleasant music combined to provide a memorable evening.

On Saturday noon class members were once again luncheon guests of Bill and Elsa Marlow in their spacious and attractive hilltop home in Brookline. This most pleasant occasion permitted further catching up on each other's activities and strengthening the ties of friendship.

Special thanks go to the local committee on arrangements including Bill Marlow, Charlie Kickham, Si Elliott, Sam Epstein, and Jim Sacchetti.

Alexander Marble

1932

Forty-two of the seventy surviving members of the Class of 1932 participated in some or all of our forty-fifth reunion. Six hours of CME credits, plus an incidental tax deduction, stimulated many to attend the Scientific Symposium on Thursday. Meaningful reuniting did not begin, however, until that evening when, after open-bar cocktails and a sumptuous dinner at the Marriott Hotel, President Frank Cutts asked each member to detail his current activities. The following were among the many outstanding reports. Mark Altschule described *Medicine at Harvard*, a history of the school written by Harry Beecher and himself, which will be published by the University Press of New England in October. Jack Gibson recited an epic poem he recently composed. Americo Savastano, who now enjoys an international reputation in sports medicine, confessed that his greatest athletic achievement was blowing the tuba in the URI band.

Friday morning was cold and wet but the tents in the quadrangle held up, the loudspeaker worked and the talks were appropriate. Carl Walter, chairman of



the alumni fund, reported that our annual contributions now total more than those of any other class in the school's history. We also have the highest percent participation and were the most generous givers in 1976. Not bad for sons of the Great Depression.

The weather cleared just in time for class pictures. After lunch, twenty-eight classmates, many with wives, were taken by bus to Woods Hole, and thence by ferry and another bus to the Harborside Inn at Edgartown on Martha's Vineyard. The widows of four classmates accepted invitations to join us. Saturday, in a delightful setting, with perfect weather, we renewed our friendships through unplanned, unhurried and uninterrupted conversations on the lawn, at the bar and at poolside. The activist minority swam, played tennis, bicycled and/or viewed the mechanical shark used in the movie "Jaws," now being tested for use in a sequel. The Class of 1957, which enjoyed the same accommodations, joined us at cocktails,

a clam bake and a Saturday night party at which George Wilkins was again judged the world's finest pianist.

The group returned to the Marriott Sunday afternoon, truly reunited with each other and with the school.

Eugene A. Gaston

1937

The weekend started on Thursday with the scientific sessions at the Medical School. I was not present, but it was reported that they were of excellent quality and well worthwhile. Thursday evening found many of us at the gracious home of Hans and Edith Waine on Beacon Hill. Everyone was much impressed by their attractive home with its own greenhouse and beautiful flowers. Many thanks go to Hans and his wife for their hospitality.





1942

Now that the members of the Class of 1942 who returned for the festivities of the thirty-fifth reunion have dispersed again to their various homes and regular activity, one can view the occasion in perspective. It was great fun! A large percent of the returning class signed up for (and presumably attended) the Scientific Symposium on Thursday, June 2. At the conclusion of this intellectual exercise, twenty-six classmates and twenty-five wives gathered at a hospitality suite at the Colonnade Hotel for an appropriate revival meeting.

On Friday, Alumni Day, there were many excellent and interesting talks. The weather was not too cooperative because of a cold Canadian wind blowing through the tents. However, we all survived without problems. The talks were followed by the alumni meeting, at which time we had the pleasure of hearing President Bok of Harvard introduce the new Dean, Dr. Tosteson, who then said a few words. Dr. Ebert, the outgoing Dean, was accorded several well-deserved accolades.

Later that same day, several hardy souls ventured forth on a sight-seeing boat ride on the Charles River. Others of us spent the afternoon reminiscing about old times, revisiting the hospitals where we interned, or just plain napping. We all finally gathered for the reunion dinner at the Museum of Science. It was indeed a most pleasant informal dinner party. Several short speeches were made. Lester Yee was

accorded the prize for coming the longest distance to the reunion, while Hans Waine was awarded the prizes for the shortest distance traveled. Jack Nunemaker had made a special gavel for the occasion which was presented to our permanent President, Joe Johnson. It is hoped that this gavel will reappear at all of our major reunions henceforth, and may help keep the Class of '37 in order.

On Saturday, about sixty people gathered at our home in South Dartmouth for an informal clambake. The weatherman cooperated to the utmost and the day was warm, calm, and crystal clear.

All in all, it was a most pleasant reunion, and everyone seemed to have a good time.

Joseph R. Frothingham

Following the Alumni Day program and luncheon in the Quadrangle, the class proceeded overland to the next watering stop at Chatham Bars Inn on the Cape; a total of 101 classmates and wives partook of some of the weekend's activities. We were fortunate in having commandeered our new dean for the first part of the weekend, and after dinner, Friday night, we gathered informally with him in one of the cottages. Dean Tosteson fielded innumerable questions expertly, and certainly that pleasant, informative and entertaining evening was the high spot of the reunion. On Saturday and Sunday, a variety of activities were available, sufficient to sustain everyone from the most vigorous to the completely sedentary. Fortunately the weather, while hardly tropical, was clear and the outdoor clambake at noon was a rousing success. Service, accommodations and food were good and we finally drifted off on our separate ways on Sunday. Relaxation, renewal, nostalgia and anticipation — of the fortieth!

William V. McDermott



1947

The Class of 1947 continues to top all reunion attendance records, reflecting the unique closeness which its members feel towards one another. In this year's group, the chairman found old friends not here on previous occasions, including Ted Endsley, Steve Deckoff and Joe LaBarre, who, incidentally still owns a trumpet and claims he can now play something besides reveille.

Alumni Day exercises were of course highlighted by various speeches in honor of the retiring dean, Dr. Ebert. The various standing ovations were a welcome opportunity to warm the hands and get the blood circulating. Awards for Most Entertaining Speaker clearly went to our own Cheves Smythe and that for the Most Profound went to Dean-designate, Dan Tosteson.

Chatham Bars provided a magnificent setting for a grand get-together — golf, tennis, dancing, and just plain comparing notes. The food was excellent, the company superb, supplemented by the friendly thirty-fifth reunion group.

It is amazing how well everyone looked, especially the wives. By departure time, people were already thinking about our thirty-fifth. Lots of suggestions were made. How about Bermuda?

William J. Porell



Senft serving as the navigator. Using a unique remote microphone and speaker system numerous members of the class as well as their spouses were asked to comment on what twenty-five years out of medical school had meant to them. There was enthusiastic participation by all present, with individual reminiscence, philosophic commentary and educational critique on the significance of the Harvard Medical School and the twenty-five intervening years.

Most of those present and commenting agreed that HMS had had a great deal of impact on their medical education, attitudes, and professional life. All enthusiastically endorsed their HMS experience. Many expressed the concern that if they were to apply for admission to HMS today they might not gain acceptance. (Editor's note: if HMS is not taking individuals of the type represented by the class of 1952 it is in serious trouble.) Most agreed that their career aspirations had been generally very satisfactory and had they to do it all over again, would not change significantly. Many were concerned about the current admissions policies of HMS regarding their offspring and the associated stigma that they bear as direct relations to alumni. There was some lively discussion as to whether this particular time in one's life represented the peaking of professional, family and social achievements and whether one should now be looking to diminishing achievements or retirement as opposed to expecting further great accomplishments.

The discussion lasted well into the evening because of the enthusiastic participation and was adjourned by the moderator Al Senft when the yawns and fatigue overcame the erudition.

Saturday morning everyone was up early to play tennis, golf, and sight-see. In the evening after informal cocktail parties the class sat down to a traditional New England clambake, which was thoroughly enjoyed by all and then adjourned to a small room for a slide presentation by Al Senft and Neil and Pat Phorliksen. There were lots of oooh's and aaah's as old scenes recalling our younger days at the Medical School and previous class gatherings were shown. Al conducted more interviews and stimulated joke telling by Cochran, Pinkus, Weiss and Feldman.

On Sunday after breakfast most everybody departed, but several of the tennis diehards like the Hayneses, Reichards, Malcolms and Donovans stayed on to settle some of the tennis competition initiated on the previous day.

The award for traveling the furthest to the reunion was given to Dick Moersch who arrived on Cape Cod from Greece by way of Seattle. There were also many representatives from the west coast including the Tabers, Thorliksens, Rial Cummings, and the Van Der Veens. One foreign country (Texas) was represented by Ann and Bill Kraus.

Merrill Feldman

1952

On Thursday evening the class gathered at the new Harvard Club on Federal Street overlooking beautiful downtown Boston. Along with the invited members of the alumni council, incoming Dean, Dr. Daniel Tosteson, Dr. Perry Culver and representatives of the alumni office, were the convening members of the class of 1952 and their spouses — a total of 130 individuals. After cocktails and a delicious roast beef dinner the class broke up into small groups to pursue renewal of acquaintances and friendships as well as some sight-seeing in the Quincy Market and Waterfront areas of Boston.

On Friday, after the Alumni Day program, thirty members of the class along with spouses and families set out for the Red Jacket Motor Inn at South Yarmouth on Cape Cod. After drinks and informal get-togethers, everyone adjourned to the dining room for a buffet dinner. Following the dinner the class set sail on the sea of nostalgia with Al



good to see all of you again; I hope those not there will partake the next time around.

Daniel J. O'Connor

1962

Once again, the Class of 1962 presented a minimum at the Alumni Day picture and a maximum at class reunion functions. Fifty-eight of 137 classmates attended one or more of the three days' events.

On Thursday evening at the Parker House, twenty-nine classmates and twenty-two spouses and guests attended a short four hour cocktail party. This certainly could have accounted for a significant number of absentees on Friday morning. On Friday evening, seventy-eight of us, including forty-one classmates, gathered at the State Street Roof for a rather somber dinner dance. A clear evening with a panoramic view, complemented by an excellent dinner, just the right amount of liquor and quiet dance music (George May style) and the usual outlandish awards and remarks by Bill Donahue thrust upon members of our class who would not have tolerated such behavior fifteen years ago, made for a very pleasant gathering.

On Saturday, seventy-one adults including forty-one classmates, plus sixty-three offspring, departed on the cruise ship Bay State to George's Island for a clambake and outing. Edward Rowe Snow gave a narration on the trip to the Island and then a tour of the fort on George's Island. Literally, the audience was captivated by his style. The weather was perfect for a clambake, beer was just enough, and everyone breathed a collective sigh of relief when Bill Donahue did not attempt any athletic endeavors beyond singing Irish lullabies and holding his beer cup steady.

A special thanks to Graeme Hanson who singlehandedly outwitted the fifth reunion class from the Harvard Business School, thus allowing our group to be served first at the clambake. Everyone had a good time: everyone promised to return for the Twentieth and I will keep them to this promise. I

1957

For a few brief evening hours on June 2, Vanderbilt Hall rose from its jaded slumbers to enjoy again the high spirits and gracious camaraderie of the men and women of HMS '57. The long and pleasant weekend was marked by the appearance of approximately forty classmates and an almost equal number of either spouses or appropriate companions.

The hardiness of this selective group was severely tested by an enteric assault both virulent and, happily, short-lived. The culprit, it was agreed, had to be the "creamed chicken" served at Friday's Quadrangle luncheon. Displaying once again the resilience which characterized its undergraduate efforts, HMS '57 collectively generated a more favorable peristaltic mode and turned to pleasurable pursuits.

Martha's Vineyard exists a medium drive and a short swim from Longwood

Avenue. Most made it safely and addressed the weightier matters of family, career comparison, and the tennis phenomenon within the protective cover of the Harborside Inn. Saturday's indoor clambake offered a convincing rebuttal to Friday's creamed chicken. Lobster and clams were dispatched in company with appropriate libations proffered in agreeable abundance.

Many came from California, others from the Southwest, the Midwestern heartlands and of course the durable Easterners, the New Englanders, and those who have had to settle for New York and New Jersey. Age expressed its varying toll and in many instances its assaults were well concealed by hirsute heraldry. I don't believe the author is quite ready for a mustache, yet.

As with the fifteenth at Chatham Bars, the gathering and the interchanges were remarkably relaxed and natural. It is difficult to express the general sense of good will and pleasure, the blunting of forgotten differences that so pervasively ruled these gatherings. It was



know that others who did not come, could not. Several would not. To reecho five years ago, "we're gonna getcha, Frank Neelon."

Samuel H. Kim

1967

The festivities started off with a wonderful cocktail party and supper at Bruce Donoff's charming home in Brookline. We owe our gratitude to Mady Donoff and Fran Putnoi for making it all turn out so well. There was genuine good feeling as classmates reunited, only sometimes needing to glance at name tags to recognize faces covered by mustaches and beards, heads uncovered by alopecia prematura aggravata unnecessary, and bodies ballooned by some sort of "good" life. There was a little talk of those always upgraded "good old days," but mostly we wanted to know how each of us had structured his or her life into practice, academics, children — and vacations.

Friday afternoon's luncheon on the quad will be remembered in infamy! Friday night we gathered at the Aquarium. Len Ellman and Lloyd Axelrod put together a full evening of cocktails, a fascinating aquatic show, and dancing to the nostalgic warbling of Johnny Mathis and Buddy Holly, which everyone enjoyed.

Nobody had trouble awakening Saturday morning. In fact, there was a path beat to many bathrooms around town, as *Bacillus Harvardicus Tourista Cathartica* sounded its alarm. Most of us recovered enough to meet and eat at a sumptuous clam and lobster bake at Dick Shulman's parents' lovely coastline home in Swampscott. We thank Dick, Judy, and his family for making possible a wonderful, relaxing ending to our long weekend of festivities. Two HMS babysitters entertained the kids, while the epidemiologists of the class hypothetically traced the *tourista* to Friday afternoon's chicken à la king — and the I.D.'ers took book on the identity of the etiologic agent. Goodbyes were warm, and we all began looking forward to the fifteenth reunion.

Melvyn L. Lurie



1972

The fifth reunion gathering of our class proved to be an enjoyable and congenial event. The weekend opened with the formal alumni gathering at which the alumni met for the first time the new Dean, and expressed their appreciation to Dean Ebert. This was followed by a well attended cocktail party at Vanderbilt Hall. On Saturday, Dr. Culver continued the generous tradition of inviting the fifth reunion to his home in Lincoln, where we all enjoyed a delicious clam-bake, beautiful weather and were delighted by the numerous offspring.

The Cantrils came all the way from St. Louis preaching the virtues of retina surgery. The Rettigs came from Dela-

ware, where Dianne has been administering a maternal and child health program, and Phil has been working for the Bureau of Disease Control. They are soon to be off to Dallas. Les Schlesinger and Saline, with a new daughter, expounded on virtues of private practice to those of us still in the womb of training. The Boston contingent of course was well represented, with many coming either to the cocktail party or the clam-bake.

The entire gathering was a relaxed, friendly affair that gave us an opportunity to renew and in some instances make friends with those whom we have not seen in five years. We hope that the success of these events will continue in the future.

Daniel Burnes



The following comprises the fifth of twelve "chapters" of Norma Farber's comprehensive verse and prose manuscript, "Year of Reversible Loss," whose central figure is her late husband Sidney Farber '27, who died in 1973. The concluding chapter of this piece was published in the Christian Science Monitor. She eloquently weaves the austerity of death and the repose she seeks in consoling memories and in the panoply of nature. Norma Farber's poetry has been published widely in reviews and anthologies. In addition to collections of poems and translations she has written a dozen books for children. As I Was Crossing Boston Common was nominated for the 1976 National Book Award.

TEACH, DELIGHT, AND MOOVE

— Franciscus Junius

HEART (680 grams):

RIGHT ATRIUM — DILATATION AND HYPERTROPHY, MODERATE

RIGHT VENTRICLE —

HYPERTROPHY (0.3 – 0.5 cm.)

DILATATION, MODERATE

FOCAL FIBROSIS

LEFT ATRIUM — DILATATION AND HYPERTROPHY, MODERATE

LEFT VENTRICLE —

HYPERTROPHY (1.5 cm.) and DILATATION

OLD HEALED INFARCTIONS, ANTERO-SEPTAL

AND POSTEROLATERAL (5 x 4 cm. and 5 x 7 cm. RESPECTIVELY)

POSTERIOR WALL —

THINNING TO 0.4 cm., WITH FIBROUS SCARRING OF WALL

I am drawn, once again, to Rembrandt's *Anatomy of Dr. Tulp*.

Rembrandt visited the public anatomies of Leiden and Amsterdam. Like his pictorial record of them, they were designed to instruct, to entertain, to move.

Chicory blue,
that blue the sky reflects
between cloudgusts of clover.

The pathologist has sent me this autopsy report. Your terminal episode was probably an arrhythmia, or a very recent extension of your infarction.

Of the larch:

Tree decidedly to my taste:
deciduous,
with the look of everlast.

Whatever you were, you are no longer. This is the message of the funerary theater. A life has withered. The innermost secrets are brought to light. Heart, lungs, liver, spleen, stomach, kidneys, all parts yield their lesson to the living. How astonishing in situ, the human accidents. In the remains of the defunct we learn the varieties of our enemy death. And since the bodies on anatomical display in those Renaissance theaters were the *corpora vilia* of criminals, the answers sought were found, by paradox, in the most degrading specimens. Evildoers did well in dying. Skins without voices, they told truths.

Dawn of the dandelion moons,
morning of silent planets
swum, full rounds, to foamy view.



Questions from the audience are admissible, provided they are decent and serious.

Let me ask, then, with Petrarch: In human affairs, what thing is greater than Death?

Our ancestors have recognized that magnitude. They make the grandest spectacle of public anatomies. "Furthermore a properly adapted theater should be located in a spacious and well-ventilated place, with ranks of seats like those of an amphitheater . . . The seating arrangement is to be according to rank."

Royal, at the river edge,
a stately solitary pair
of loosestrife.

Inflated head
of the bladder champion.
Often crowned.

How proudly the living cling to their substance. Nor will they permit one of their favored kind to be counted among the anatomized cadavers. Only the half-lives, the criminal and the unfit, may be ritualized in this high-ranking entertainment. "Only humble and unknown persons, then, and those from distant regions may rightly be claimed for dissection, that there shall be no outrage to neighbors or relatives. Those are chosen who have been strangled by hanging and who are middle-aged, neither lean nor fat, and of rather large frame, that their components may be of more generous size and more distinctly visible to the onlookers."

This golden girth of day
is shriveling in its skin.
The sack is leaking its summer light.

How every disguise, every distancing of death, reveals its wry failure. The secrets of nature we are probing on the autopsy table, these are our very own consuming mysteries.

A first leaf shivers out of the air.
Now let the mind begin to shed
what shudders in the cold.

Of the new moon:

Can't see the bird,
only the platinum talon.
Can't guess the bough it's gripping.

We can't forego pomp and drama. Death continues to be cause for display, for celebration. Our practice of funeral rites continues, a parallel to Rembrandt's spectacle of the dissection-table. Both stimulate excitement. The post-mortem examination has long since been removed from the arena of public entertainment. But funeral ceremonies persist, prepared exercises in morality and metaphysics. Also, perhaps, in aesthetics. And in self-defense?

Sensitive shoot honed into armor:
the leaf of the thistle
is consumed by few creatures.

If I can discover a moral or a metaphysic in death, maybe I shall be finding a means to rationalize loss. Yet I must admit that the longer and closer I live with loss, the less it allows itself to be "interpreted," manipulated. Death exists. Loss *is*.

Whoso loses the life of another —
what does he find
save its loss?

We spend too many centuries of our histories, decades of our lives, converting, controverting (subverting?) a simple fact. Shouldn't we rather support our observation with sensitive recognition? To live *sub specie mortis*: is it more threatening than to live under the sun, our life-giver? Isn't it of the same order?

The end is the end
only while I wait
uncertainly for it.

From green to taupe,
the fruit of my fig-tree ripens
till I consume it.

From green to deep, we ripen into the mouth of death. What shade are you now?

No wind, a dead-still space.
Sails hang, clouds pall.
A stasis of staying.

Even harder than proceeding:
delaying.
As for tinder to dry.

Color starts to flake.
Metallic ragweed sculpture
rusts along the river.

But we are moving, moving. . . . In reality there's no such state as arrest. Inventing a halt, we take pictures of ourselves, of one another. Portraiture as an art form has been closely linked with death. The loss of individual personality may be countermeasured by a realistic painting. We record our perishable appearances as a hopeful safeguard against that certain something further. Louis, Duc d'Orleans is saluted for his ordinance (1403) "que la remembrance de mon visage et de mes mains soit faicte sur ma tombe en guise de mort."

How shall I know danger?
The dove can look a hawk,
so free it swoops.

I'm tempted to discard all your photographs. They no longer resemble you, my remembrance of you, which is changing as certainly as I change.

Of the half-moon:

That gilded roof, high, humped
just fits the night
as a dome its building.

Both are tilting.

Of the locust pod:

A single season's tannery
will turn this suede green pelt
to tough brown hide.

I keep at hand a snapshot of you and an infant grandson. You are seated, holding him in your lap. He holds your thumb. You stare gently yet fixedly at each other: his look as serious as yours. A search flows both ways between you, each of you seeking some answer, some certification from the other. You are both in profile: the lines of half your forehead, the heavy lid of an eye, your flat left cheek and intricacies of ear; Billy's sweet arc of brow and solemn upward gray-blue glance, his round of cheek, his definitive — already! — intricacies of ear. On the diaper under his head an eighth-inch of shadow silhouettes his features. From a vase behind his head a marguerite halos him modestly. Parts of fifty books are visible in the background shelves. I am making some effort to record these details. But what I really perceive, what remains with me between the occasions of looking, is the interchange between man and child, the movement, the music, back and forth, like no song ever heard sung. Music, as we are accustomed to experience it, advances in time. This song between you and Billy advances and reverses. No, it moves instantaneously in both directions. It's a moving suspension, a two-way flow. The flow is what I'm after. A current between us. It is possible?

Now let us celebrate division,
for love arises between,
only between.

A hint, an intimation only? Like those flashes of carp I almost saw in the June river?

“Knowledge is memory.”
Then it is ignorance I pursue,
a forgotten future.

Of the resinous tree of memory:

Keep flowing,
never fixing time
into stone timelessness.

Today, walking again by the river, I saw plainly a flat dead orange ellipse floating on the surface. No need to guess at it, the corpse was there, an object, defined, static. The interchange was missing, the interplay between fish and flood. My search continues, like yours and Billy's. The search continues between us.

Of the full moon:

A tight drum-head,
cloud-colored as a timbal skin.
Knock, to know if music's within.

One brazen wheel
on a macadam sky,
Suppose the whole chariot.

Already a first aster
starring the weed-deep riverbank:
a reversal, sky at my feet.

Dorothy Murphy . . . "a dear friend"

Following the news of Dorothy Murphy's death, the alumni office received letters from many alumni telling of the affection and admiration that she first inspired in them as young medical students, and of the friendship that endured and deepened over the years. A number of these accompanied contributions to the Dorothy A. Murphy Scholarship Fund, which now stands at \$112,321. The fund has made two awards a year since it was activated in 1971, and has so far helped eight students through HMS. We have excerpted some of these personal tributes, which we know are echoed by all of the alumni for whom Dorothy Murphy cared so much during her fifty-eight years of selfless concern for Harvard Medical School.

Dorothy had been with HMS a comparatively short time when those of us who transferred in our junior year entered the Medical School. The Class of 1922 had a high percentage of transfers due to World War I disruptions. Dorothy's interest and encouragement in this group of students was most helpful. Many of her earliest admirers were in this group of alumni. We have lost a dear friend.

Paul C. Morton '22

She was one of the most devoted and delightful persons I was ever privileged to know. She will be missed by all of us.

Robert S. Buol '23

When I first arrived at HMS in 1921, Dorothy was the first real personal contact that I had with the School, and it proved to be one of the most enjoyable and rewarding relationships of my entire life . . . It was always a joy to be with her . . . We will always remember her with love and affection.

LeMoyne Snyder '23

Our relationship was to me a most cherished one, starting in 1922 and proceeding for the succeeding fifty-five years with increasing warmth.

William H. Potts '26

I applied for admission to Harvard Medical School after graduating from college in 1923 and was under the impression that they would be glad to accept me. It came as a great shock to find that I was not accepted. About this time I got to know Dorothy Murphy, who told me that if anything turned up, she would let me know. I was enrolled in McGill when I received a telegram stating that a vacancy had occurred. I immediately returned to Boston. I have followed with interest her rise to fame and got a vicarious thrill out of her many honors.

Robert S. Flinn '27

Friend and counselor for thousands of medical students was Dorothy Murphy. Had it not been for her, I would never have finished HMS. I am sure there are many of my class and schoolmates who join me in mourning the passing of this remarkable person.

Harold H. Hamilton '30

To many she was the sole remaining link to the School for those who graduated forty-five years ago and since. When visiting with her the many changes that have occurred seemed to vanish in the warmth, interest, and memories she held for each of us. At no time in the past has a woman so completely interwoven her life into the spirit, policies, and amongst the alumni of the Harvard Medical School, nor is it likely such a person will ever again arrive on the scene. HMS was her total life and concern, and her contributions to the School, direct and indirect, over a half century are so immense as to defy description.

When I was struggling along as an undergraduate, with death and disease in my family, she was a cheerful and sustaining friend — and since 1972 when I was permanently crippled by a spinal cord infection, her consolation continued. Her remarkable memory accurately stored the details in the lives of thousands of alumni, their successes and their troubles. . . . I shall always be amazed at the circumstances by which a young woman moved so completely over the years into the tangible and intangible affairs and life of a great school, its students and alumni. Many of us will be lonely to return without her greeting.

Donald C. Gates '32

It is indeed difficult to put into words what Dotty meant to so many classes, over the years. But it developed into an all-inclusive friendship, on a very mature basis, with nothing of the mother hen nonsense. She was every HMS man's best girl in the finest sense, and we felt a great love for her. A generation, or two, or three, of Harvard doctors give their patients or their work a little of Dotty Murphy every day, without knowing it.

John G. Gibson '32

She was a lady of charm and many talents and HMS will miss her badly. . . . We rejoice that we knew such a great person, and commend her to the Lord.

The Rev. G. Douglas Krumbhaar '32

I felt she understood what I was trying to become.

James Forrester '53

